State of Maryland / Department of Health and Mental Hygiene 2004 05501 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 4,2004 **Physician** Ennis Moses 1314 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Annapolis

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Wooths | Days | Hours | Min. | July | 17,1923 Anne Arundel Medical Center Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 1 M 2 □ F 213-28-2106 80 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location raf, or Items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Anne Arundel Lothian the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5570 Greenock Road 20711 USA Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Black Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry of other than "natu Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental item 27 is marked of other traumatic eve Mental William Ennis Hettie Harris 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 812 W. Chesapeake Beach Rd. Owings, MD 20736 Carrie Spriggs/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of F Important: If ite any injury or ot 20028. 1 DABurial 2 □ Cremation 3 □ Removal from State Cemetery Moses 2/11/2004 Lothian, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition **Physician** unon resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown ρ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐Unknown ZNo 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2□ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA ٩ 1 Tes 2 ER/Outpatient s after death.
I Director: After this of in by the funeral d 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred 27 Manner of Death Medical Certification: 1 Natural 2 Accident 5 Pending investigation М 1 □ Yes 2 □ No 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral L completely filled Tartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Mdnth, Day, Year) 29b. Signature and title of perpifier 29c. License number MD npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 32. Registra s Signature 31. Date filed (Month, Day, Year) State 2004 FEB 0 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05502 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 5^{Day} Day 2004 **Physician** 1:00PM Franz Friedrich.Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles 13665 Piccawaxen Creek Road Newburg Months Days Hours Min. Feb. 28 1919 9. Birthplace (State or Foreign Country)
WASH DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**7** M 2□ F 214-14-2930 84 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-1 show the Medical Examiner must be notified at Director 1 ☐ Yes 2€ No MD Charles Newburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13665 Piccawaxen Creek Rd. 20664 USA 238 death. Funerai 14. Race - American Indian fems 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give 1941-1945 Yes 28 No Specify: 1 Never Married 2 Married Specify: White 0 Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ** any injury or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) Steamfitting Steamfitter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Oscar Herman Friedrich Mary Smith Friedrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eloise Friedrich/Spouse 13665 Piccawaxen Creek Rd. Newburg, MD 20664 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cem. 2/11/04 Cheltenham, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²²AREHART ECHOLS FUNERAL HOME, PA MOO945 P.O. Box 567 LaPlata,MD 20646 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 1-801 nama /Medical Due to (or as a consequence of): Examiner Ut Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? certificate 2 XNo 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certified 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7C Post Office Rd. Waldorf, MD 20602 <u>Shankar Rath, M.D.</u> 31. Date filed (Month, Day, Year) FEB 1 0 2004 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of Health ar rtificate of Death		iene 200	4 05503
-	Physici /Medic Examir	al	Dorothy Leona Grav A. Facility Name (If not institution, give	7		4b. City, Town, or Location of	2. Date of Dea Month February Death	Day Yea	01:50 M
	Funeral Director		221-18-7555		e (In yrs. last birthday) 76 Yrs.	Havre de Grac	e	Harfo	
Ī	// faryland	ъ	Usual Residence of Decedent 10a. State 10b. County Maryland Cecil		10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-1 show any injury or other treumatic svent, I'm Medical Evarther must be rectified at ODGe.	ral Director	Maryland Cecil 10e. Street and Number 13 Pin Oak Drive	-	Peri	yville 10f. Zip Code 21903	1	Og. Citizen of What C	
920	urs after de: el', or Items Eversiner m	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, if ☐ Yes 2【☐ No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	Black, Wh	nencan Indian, hite, etc. White
21215-0036	within 72 ho ane. then "natur he Medical I	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5	(Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	of working	16b. Kind of Busines	
Maryland 2	uld be filed Mental Hygie irked other itic svent, II	To Be Co	8 17. Father's Name (First, Middle, Last) Wrightson T. Dill				s Name (First, Middle, Market)	Own Hom Maiden Surname)	e
», Mary	and 2 sho lealth and h m 27 is ma		19a. Informant's Name/Relationship (T Lana Punchak/Daugh		13 Pi	ng Address <i>(Street and Number o</i> n Oak Drive, Po	erryv <u>ille</u> ,	Maryland	21903
altimore,	nit. Pages 1 artment of H ortent: If ite injury or ot		20a. Method of Disposition 1 Burial 2 ACremation 3 1 4 Donation 5 Other (Specify, 21. Signal re		Mayerdale		oruary 4, 2004	Newark, D	elaware
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	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Chron	a consequence of):	uctive Pulmon	any Dele	asc	Interval Between Onset and Death
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<u>a</u>	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions co	ntributing to death bu	it not resulting in the ur	nderlying cause given in Part I.			to the cause of death?
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Division	To the Hospitel or Attending Pr within 24 hours after death. To the Funerel Director: After to completely filled in by the funera	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm, stre . (Specify)	et, factory, office	28f. Location (Str. City or Town,	eet and Number or R , State)	ural Route Number,
	the Hospi thin 24 hou the Funer mpletely fill	Medical	one)	sician: To the best of ner: On the basis of and manner stat	examination and/or inv	occurred at the time, date and prestigation, in my opinion, death	occurred at the time, da	te and place, and du	e to the cause(s)
-	7 3 2 0	_	29b. Signature and title of confiler	- 170	art (harrage) 7	29c. License number D32-609		d. Date signed (Mon 2f3L0 4	n, Day, Tear)
	1		30. Name and address of person who co Kammeelm Milhau 31. Date filed (Month, Day, Year)	mpleted cause of de	Revolution	st HouseDe	Grave TH	0 21078	
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State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** LORNA MAY HEIN FEBRUARY 2004 4:30am /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner LA PLATA

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

May 4 1926 CIVISTA MEDICAL CENTER CHARLES Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 484-20-7912 77 Yrs. Director Iowa Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. Count Itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar most by motified at 1 ☐ Yes 2 录No Director Maryland Charles White Plains 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20695 USA 4551 Tate Street Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White à 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Etta Stephens Klatt Emil Klatt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paulette B. Edwards (Daughter) 4551 Tate Street White Plains, MD 20695 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 1 Department of H important: If its any injury or ot once. 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2-5-04 Alexandria, VA Metropolitan Crematory 21. Signature of Furteral Service Licensee 22. Name and Address of Facility Eberwein Funeral Services M00173 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4433 White Pls. La. White Pls., MD 20695 Approximate Interval Between Onset and Death ARCINOMA OF BREAST Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): the attending physician a hed for use as the burial-P.O. Box 68760 Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) 1 Type 2 No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by DIJGADE 1 Yes 2 No 3 Probably 4 Unknown Completed PHROINTESTINIAM BLEEDIN 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? certificate has 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 patient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 2 this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Menth, Day, Year) 29b. Signature and title of certifier 2004 D-44436 30. Name and address or person who completed cau ie of death (Item 23a) (Type, Print) PATEL MD 102 PAUL MELLON COURT WALDORF MARYLAND20602 ASHVINKUMAR J. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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			Millennium He 5. Social Security Number	alth 6. Sex			ation last birthday		gewat ler 1 Year	er If Under:	24 Hrs.	8 Date of Bir		Anne Ar		te or Foreign
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	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 🖒 Certif	ying Phys	ician: To the t	pest of my kn	owledge, dea	th occurr	ed at the tim	ne, date an	nd place, a	and due to the	cause(s	s) and manner	as stated.	
	n 24 h	Medical	(Check only 2 Medic	al Examir	er: On the bas and manne	sis of examinates of stated.	ation and/or ii	nvestigati	on, in my or	pinion, dea	ath occurre	ed at the time,	date an	d place, and d	ue to the caus	6e(s)
	Withi Totl	Ž	29b. Signature and title of cert	fier					29c. License		5			ate signed (Mo		
			Nay	0/2	Sun		mo		レス	026	5		1-66	way	1,200	-
(0		30. Name and address of pers	2 ~ .	i	of death (Ite	m 23a) (Type), Print)	sull	e RS) . (Nost R	We.	My	20.77	8
	-	ate	31. Date filed (Month, Day, Ye		32. Re	distracts Sign	ature			- 4	,	- (-	6	1	- '	
6	Regist		I FE	B 1 1	2004	Moone	K	1	- M							

sician	1 - For UnpendIte Registrar 1. Decedent's Name (First, Mich.)							2. Date of Deal	th		3. Time of Death
edical	Choile Molid	sa Holland	Ē					Februa:	ry 87,	2004	1628 P M
miner	An Constitute Manage Office Annalysis	ion, give street and n	umber)		4b. City, Town	, or Location	of Death		4c. Count	y of Death	
	Calvert Memo					e Fred	T			lvert	
eral tor	5, Social Security Number	6. Sex 1 □ M 2 1 F	7. Age (In yrs. 39		If Under 1 Ye Months Day		Min.	8. Date of Birth (Month, Day) 4/13/19	Year)	9. Birthp	lace (State or Foreig try) DC
lor	217-78-5438 Usual Residence of Decedent		J.	J	i			4/13/1:	304		DC
	10a. State 10b. Coun	ity	10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
leted by Funeral Director	MD	Calvert			Hur	ntingto	own				1 X Yes 2 □ No
Directo	10e. Street and Number				10f. Zip Code	Ð		1	0g. Citizen of	What Coun	try?
i e			and at Ever's 11	6 40		20639		-if Manager	14 Do	USA ce - Americ	an tadiaa
Funerai	11. Marital Status 11 Never Married 2 M.	Armed F	cedent Ever in U. Forces? : 210 No		Was Decedent of If Yes, specify C		n, Puerto F	Rican, etc.)		ck, White,	
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٩	Raymond Edwar			10b Mailie	ng Address (Stre	of pad Numb		th Dais	4		Code
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1	Raymond Holla 20a. Method of Disposition	and/Father	20b. P	lace of Dispo	Stinne				20c. Location		wn, State
once.	1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		n State		natory`or other ; Cemeter	' 1_	2/13/2	2004 F	Hunting	rt.own.	MD
oj.	21. Signature of Furneral Serve		1101.		2. Name and Ad	100		-			Home, PA
oud	1 - Co. (1	Jart	_	P) Box 43	RO. Dur		_)754	iiiei ai	. Home, i.e.
	23a. Part1. Enter the disease, shock, or heart failure. L	or complications that	caused the death						13.5 M = -0		Approximate Interval Between
n	Immediate Cause (Final disease or condition	_	acidosis							4	Onset and Death
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	Sequentially list conditions, if any, leading to immediate	b									
-ine	if any, leading to immediate cause. Enter Underlying Cause (Discass or injury	₹ Due to	o (or as a consequ	uence of):							
Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a consequ	uence of):						-	
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1 77		U									
Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Ectopic pregna	nev				ate of delive	
sicis	in the past 12 months? 1 Wes 2 No 9 Unknown		gnant at time of de		Other (specify)				Mo	onth	Day Year
Phy	9 V Unknown			delegate de la companya		ia Dadi		22a Did tob		4-11 4 4b-	a server of death?
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an	<u> </u>							24a. Was a	y !		sy findings available apletion of cause of
		and .							No No	1 Yes	2 No
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To Be C		ding (Mo stigation	riui, Day 19ai)	Injury		Yes 2	No				
To Be C	1 ♣ Natural 5 ☐ Pend 2 ☐ Accident inves	d not be	ce of Injury - At ho ding, etc. (Specify	me, farm, str	eet, factory, office	е	2	8f. Location (Sti		ber or Rural	Route Number,
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Certification: To Be C		mined 286. Plac							4 4		
Certification: To Be C		ring Physician: To the	basis of examinat	wledge, death	n occurred at the vestigation, in m	time, date ar y opinion, dea	nd place, an ath occurre	nd due to the ca d at the time, da	iuse(s) and ma ate and place,	anner as sta and due to	ated. the cause(s)
ertification: To Be C	29a. Certifier 1 Certify (Check only one)	ring Physician: To the and ma	ne best of my kno- basis of examinat nner stated.	wledge, death ion and/or in	vestigation, in m	time, date an y opinion, dea ense number	nd place, and place, a	d at the time, da	ate and place,	and due to	the cause(s)
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edical Certification: To Be C	29a. Certifier 1 Certify (Check only one) 29b. Signature and title of certify	ring Physician: To the all Examiner: On the and ma	basis of examination of stated.	tion and/or in	29c. Lice	y opinion, dea	ath occurre	d at the time, da	ate and place,	and due to	the cause(s) Dey, Year)
Certification: To Be C	29a. Certifier 1 Certify (Check only one)	ring Physician: To the all Examiner: On the and ma	basis of examination of stated.	ion and/or in	29c. Lice	y opinion, dea	ath occurre	d at the time, da	ate and place, ed. Date signe Februa:	and due to ed (Month, L	the cause(s) Dey, Year) , 2004

State of Maryland / Department of Health and Mental Hygiene 2004 05507 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Ronnie Levon Holder Feb 4 2004 315 AM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Memorial Hospital Calvert Prince Frederick If Under 1 Year If Under 24 Hrs. Min. Nov 3 1941 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**√2** M 2□ F 62 579 54 5293 North Carolin Yrs **Director** Usual Residence of Decedent the Maryland 10c. City Town or Location Solomons 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner until be notified at 905e. Maryland Calvert 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20688 921 Spinnaker Way United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: White 1 2Yes 2 No 58 - 62 f Yes, Give Year or Dates: 1 Never Married 25 Married Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) instrctual training video producer/manufactor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Belton Raymond A. Holder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
921 Spinnaker Way Solomons MD 20688 19a. Informant's Name/Relationship (Type, Print) Susan A. Holder - wife Baltimore, 20b. Place of Disposition (Name of ServiceAlexandria Virginia 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place Feb 4
Metropolitan Funeral 1 ☐ Burial Z ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home Is. Rd, Port Republic Draws MD 20676 4405 Broomes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANCER LUNG Pnysician 2003 /Medical Due to (or as a consequence of) Examiner ULMONARY 5/2003 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Completed by Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9☐ Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 214104 MD 0060475 lum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL RD, PRINCE FREDERICK 20678 BUSH 100 31. Date filed (Month, Day, Year) 32. Registra Signature State FEB 0 6 2004 Registrar

			Please 1 - State Registrer	Type or Print State of Mar	yland / D		t of H	ealth and		ntal Hyg		2004	05508
	Physici /Medio	al	Decedent's Name (First, Middle, La Dorothy Security Name (If not institution, gi	Faye		Jump 4b Gilv	Town or	Location of De		Date of Dea Month	Day		3. Time of Death 8:30P
	Examin Funeral	er	Civista Medio 5. Social Security Number 6.	cal Center	In yrs. last birtl	Landay) If Under	aP1a	ta If Under 24 F		Date of Birth		Char1	es (Stete or Foreign
	Director Mode Park	or	Usuel Residenca of Decedent 10a. State 10b. County		0c. City, Town	or Location			A	igust	20		Od. Inside City Limits
	th with the N 23s or 28s-	al Direct	10e. Street and Number 106 Thomas Jef			1 Of. Zip	Code	646		1	0g. Citi	izen of What Cour USA	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23e or 28e-1 ahow may injury or other traumatic event. The Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		13. Was Decer If Yes, spe 1 \(\superset Yes		spanic Origin? n, Mexican, Pu Specify:	(Specification (Speci	y Yes or No- can, etc.)		14. Race - Americ Black, White, Specify: Wh	
21215-0036	filed within 72 ho Hygiene. other than "natun ant, ma Medical	completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)		16a.	Decedent's Usur (Give kind of wo life. DO NOT u School	rk done d se retired	furing most of	working			ind of Business/In	,
y Jump Maryland	ould be file Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Las Robert Lee Lin	dsey					ie I	Elizal	oet!	h VanDe	
	i 1 and 2 sho Health and tem 27 is my other traumy	1000000	19a. Informant's Name/Relationship David Jump/Hus 20a. Mathod of Disposition	band	10		nas	Jeffer		n St.	La	r Town, State, Zip Plata, cation - City or To	MD 20646
Doroth Baltimore,	permit. Pages Department of Important: If it any injury or o		1 A Burial 2 □ Cremation 3 ☐ 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	rsee №009	Maryl 45	and Ve	ter	ans 2	זיבו י	INEDAT	ш	ltenham OME,P.A	
•	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death)	pplications that caused the rone cause on each line. Due to (or as a company)	ERKA	P.O.F ot enter the mod	OX- le of dying	567 g, such as card	I.A diac or re	PTATA	A , M	D 20646	Approximate Interval Between Onset and Death
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.O. Box 6	e death certif the attending hed for use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 20 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tin 9 □ Unknown	Fetal déath	3 □Ectopic pr 5 □ Other (sp				111	2	23d. Date of delive Month	rry Day Year
rds, P	w requires that th been signed by should be detacl	þ	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying c	ause give	en in Part I.					e cause of death?
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Division of Vital Records, P.O. Box 6876	or Attending Physicien: after death. Director: After this certific in by the funeral director,	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigating investigating investigating determined.	28a. Date of Injury (Month, Day Y	- At home, far	me of 2 jury M	8c. Injury Work	at Nursing	g Home 28d	5 ☐ Reside	nce 6	d Number or Rura	
Di	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical Cert	29a. Certifier 1 Certifying P	nysician: To the best of miner: On the basis of e	ny knowledge, kamination and	death occurred for investigation	at the tim	e, date and pla pinion, death or	ace, and	due to the ca	uise(s)	and manner as st	ated. the cause(s)
•	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner states	u.		D-5	2289		29		e signed (Month, 1	Dey, Year)
\			30. Name and address of person who	completed cause of deal	th (Item 23a) (1						/	1	

DHMH 17 Rev 1/2001

State Registrar

FEB 1 1 2004

Nalin Mathur, MD 10 St. Patricks Dr. Ste. 404 Waldorf, MD 20603

31. Date filed (Month, Day, Year)

32. Régistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 05509 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6,2004 Month **Physician** Agnes Suttie Jones February 4:05PM'/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year)
Ther 14,1907 Charles 12654 Grosstown Road Hughesville 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 579-28-8468 **Funeral** Months Days December 1 ☐ M 2 🛛 F 96 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 7 is marked other than "natural", or Items 23a or 28a-f ahow traumatic avant, the Medical Examinar mast be notified at 1 ☐ Yes 2√2 No Charles MD Hughesville Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12654 Grosstown Road 20637 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XA If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify. ģ 3√ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Sales Clerk Air Force Base 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked of pe Ewan Brody McDiarmid Jessie Young Millar Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Itam 27 is
any injury or other trau Sylvia Bachman/Daughter 12654 Grosstown Rd. Hughesville MD 20637 20b. Place of Disposition (Name of cometery crematory or other place) altimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Brinsfield-Echols 2/9/04 Charlotte Hall, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatuse of Funeral Service Licensee M00945 AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or restriction and arrest. Do not enter the mode of dying, such as cardiac or restriction and arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Physician/Medical Examiner -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a s the burial-Box 68760. as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 20 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ate has by certificate 26. Place of Death Check only one 25. Was case referred to medical Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After t Certification: 5 Pending investigation 1∕ □Natural 1 ☐ Yes 2 ☐ No Diractor: A death. 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide within 24 hours after To tha Funaral Dira 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D45737 104 Name and address of person who completed cause of death (Item 23a) (Type, Print)
N. Gurusamy, M.D. 3328 Old WAshington RD. Walodrf, MD. 20602 31. Date filed (Month, Day, Year) FEB 1 1 2004 32. Restrar's Signature State

DHMH 17 Rev 1/2001

Registrar

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 6

	1. Decedent's Nam	ne (First Mide	dle Lasti				ertifica		-	2. Date	Reg.	110.		3. Time	of Death	
ın	Patricia									Mor		Day 2 2	Year	0741	or Doda.	
al er	4a. Facility Name (ımber)		4b. City	, Town, or	Location of De		Luary		ty of Death			
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	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birthday Months Days Hours Min. (Month, Days)								nth, Day, Ye	ear)	Cou	place (State intry)	or Fore			
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	10a. State	10b. Count	ty		10c	c. City, Town o	r Location							10d. Inside (City Lim	
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	20a. Method of Dis	· · · · · · · · · · · · · · · · · · ·	J11		20	Ob. Place of Di	sposition (Na	ame of		Date	200		•	own, State		
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		Donation 5 Other (Specify) Cemetery 2004 North East, Maryland														
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	23a. Part1. Enter	the disease, o	or compl	ications that	caused the								A Transfer	Approxima	ate	
	Immediate Cause		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Onset and Death Onset and Death													
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	disease or conditi resulting in death)	on	-	Due to	Smo	nsequence of):	1 14	ng C	-AMCEY	۲,				Onsot unc	100411	
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an	nend ite	-m#	State of Maryland / Department of Health State of Maryland / Department of Health State of Maryland / Department of Health Certificate of Deatl	and Mer h	ntal Hygier Reg. 1		05511
	5		Decedent's Name (First, Middle, Last)	2.	Date of Death	Day Year	3. Time of Death
	Physicia /Medic	al	Melodie (avo) Johnson 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location		Chryan	4c. County of Deeth	1:20AM
	Examin	er	11383 Stewart Neck Rd Princes	ss An	ne	Somer	set
	Funeral Director		138+52 +4849 1 M 2 F 46 Yrs. Months Days Hours	er 24 Hrs. 8.	Date of Birth (Month, Day, Yea 11 - 10 -	9. Birthp	stace (State or Foreign
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	10d. Inside City Limits
	Ba-f eh	Director	Md. Somerset Princess An	ne			1 Ores 2 □ No
	with th		11383 Stewart Neck Rd. 21853	3	10g. (Citizen of What Cou	ntry? ^t
	r death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Specify an, Puerto Rica	Yes or No-	14. Race - Americ Black, White,	
21215-0036	s within 72 hours after death with the Maryland liene. I than "natural", or Itame 23a or 28e-f ehow the Micdical Examinat must be notified at	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 1 Yes 2 No Specific No Spe			Specify: B	lack
15-0	in 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during molifie. DO NOT use retired)	ost of working		Kind of Business/In	
	filed within Hygiene. ther than "	Com	Elementary/Secondary (0-12) 12-th Hostess				s Restauran
Maryland	ed life	To Be		lizal	jst, Middle, Maid oeth C	en Sumame)	
Many	nd 2 should th and Mer 27 Is marker r traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num Elizabeth	nber or Rural Ro	oute Number City	y or Town, State, Zip 383 Stewan	rt Neck Rd.
	Heal Heal Ther		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c.	Location - City or To	ne, MD21853 own, State
Baltimore	Pages ment of ant: If It		1 Sourial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bowland Hill Cem.	2/13/		incess An	
Balt	permit. Pag Department Important: I eny injury o		21. Signature of June pel Service Licensee 22. Name and Address of Fac	nodew	1 - /	Navd f.	Arm Md
7	ā.		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) METASTATIC CARCINOM Due to (or as a consequence of):	A OF	BRE	AST	24 EARS
П	Examiner		Sequentially list conditions b.				
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o,	icate be executed physician and the burial-transit	Ехаг	that initiated events c. Due to (or as a consequence of):				
68760,	cate be	edical	d				
Вох		ın/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetel death 3 □ Ectopic pregnancy			23d. Date of delive	
P.O. B	law requires that the death certif as been signed by the attending 2 should be detached for use a.	Physician/M	in the past 12 months? 1 Yes 2 Who 9 Unknown Unknown Unknown S Close Fregularity			Month	Day Year
	ires that signed b	by	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Par	tl.		o use contribute to the	he cause of death?
Records,	aw requir as been si 2 should	Completed			24a. Was an		psy findings available mpletion of cause of
I Re	The ate h	Com			autopsy performed? 1 Yes 2 1	death?	
Vital	Physician: This certificate and director, p	Be	examiner?	ce of Death (C)			
of		on; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		5 Residence Describe how in	6 ☐Other (Specificiary occurred	y)
Division	eat or:	catic	2 Accident investigation 3 Suicide 6 Could not be		Location /Street	and Number or Rura	al Pauto Alumbos
Ο̈́	s after d	Certification;	4 Homicide determined building, etc. (Specify)	201.	City or Town, Sta		ar nodie wamber,
	To the Hospital of within 24 hours at To the Funeral D completely filled it	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date of examination and/or investigation, in my opinion, diagram and manner stated.				
•	To the within 2 To the comple	Me	29b. Signature and title of certifier Y 29c. License numbe	696	2 FE	BRUARY	Day, Year)
						853	
10	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 1 2 2004				
	Registr	ar	FEB LZ 7004 P. Marie A. Mariel				

			For State Registrer	State of Ma	ryland / Dep <i>Ce</i>	artment of I <i>rtificate of</i>	Health ar <i>Death</i>	nd Mental Hy	giene 200 L	05512
			1. Decedent's Name (First, Middle, La	st)				2 Date of De	ath	3. Time of Death
	Physici /Medio		Frances Virgin	ia Knight	ina			Februa	ary 5,200	4 8:00a M
	Examir	er	4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of		4c. County of Dea	
			3990 Bullitt Ne	ck Road		Marb	ury		Char	les
	Funeral		5. Social Security Number 6. S		(In yrs. last birthday,	If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da	45	
	Director		223-10-4330	□M 2 🔀 F 8	32 Yrs.	Worth Days	Hours	March	12,1921 I	Maryland
	and w		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or L	neation				10d, Inside City Limits
	taryli sho	ត	Maryland Charl		Marb					1 Yes 2X No
	28a-	ect	10e. Street and Number	<u> </u>	Halb	10f. Zip Code			10g. Citizen of What C	
	with a or	ā	3990 Bullitt N	ack Poad			CEO			
	ns 23	by Funeral Directo	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.		658 Hispanic Origin	n? (Specify Yes or No	U. S. A	
10	fler of linear l	F	1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, specify Cub	an, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	Black, Whi	
036	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specify: W	nite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show Ita Madical Examiner must be modified at	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Business	/Industry
21	thin 7	pie	(Specify only highest gra	College (1-4or 5+	life.	kind of work done DO NOT use retire	during most o	nt working		
	gien gien	Con	12	2		cretary			Self Emp]	Loyed
p	al H j	Be (17. Father's Name (First, Middle, Last,				18. Mother's	s Name (First, Middle,	Maiden Surname)	
yla	Ment arke	၉	Fred C. Jone	S			Mar	tha M. F	olley	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other treumatic event, I're Medical Exertiner must be routilised at		19a. Informant's Name/Relationship (•					er, City or Town, State,	
	of Health of Health item 27 i		Shirley J. Pos	ey Daugh		30 Bick	nell R	Rd., Mark	ury, Md.	
ore	Pages 1 ent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	œreb.	10,2004	20c. Location - City or	Town, State
Ë	ment ment: tent:		`4 ☐Donation 5 ☐ Other (Specif		Mount (Comfort	Cemet	ery	Alexandri	a, Va.
Baltimore,	permit. Pages Department of Importent: If i eny injury or one.		21. Signature of Funeral Service Licer	- //		2. Name and Addre	ess of Facility	eral Hom	D 7	20640
_	70 = 9 O		Warley h		00668	42/0 H	Awthor	ne Rd.	Indian He	ad, Md.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the cause on each line	ne death. Do not en	ter the mode of dyi	ng, such as ca		rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. CON	GESTIVE	HEAR	fan	LURE		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
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	ed .	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	cate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
8760,	be e ician buria	alE								
387	icate phys s the	dical		d						
×	death certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy				22d Date of de	
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tii	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	Day Year
P.O.	the d y the tched	ysi	1 ☐ Yes 2 ☒ No 9 ☐ Unknowh	9□ Unknown						
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	y P	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Records,	uires l signe	d by						101	res 2 □No 3 □Pr	obably 4 Hinknown
00	w requir been s should	Completed						24a. Was	20 24h Were 21	itopsy findings available
Re	he lav e has ige 2	Ę.						— autop		completion of cause of
a	ilcien: Th certificate rector, pag	e C	25. Was case referred to medical					1 Yes		2 □ No
of Vital	Physicien: The I this certificate ha ral director, page	0	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	Ctt	var	Death (Check only o		
	ट ≑ ख	7: To	27. Manner of Death	28a. Date of Injury	28b. Time o	" 30 DOX	4 🗆 INUISI		dence 6 Other (Spenow injury occurred	city)
<u>o</u>	rding th.: Afte	흝	Natural 5 Pending 2 Accident investigation	(Month, Day	(ear) Injury		rk? Yes 2∐No			
Division	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be	200. Place of injun	- At home, farm, str	eet, factory, office		28f. Location (S	Street and Number or Ru	ıral Route Number,
	= e = -	ert	4 Homicide	building, etc.	(Specify)			City or Tow	vn, State)	
	To the Hospitel or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Certifying Ph	ysicien: To the best of	my knowledge, deat	h occurred at the ti	me, date and p	place, and due to the	cause(s) and manner as date and place, and due	stated.
	he Hi in 24 he Fi pletel	Medical	(Check only 2 Medical Exen	niner: On the basis of e and manner state	xamınation and/or in d.	vestigation, in my o	opinion, death	occurred at the time,	date and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of gertifier	1.5		29c. Licens	e number		29d. Date signed (Monti	**
			▶ Kli	M		1 1/2	3885		2/6/20	04
(0 5		30. Name and address of person who	on pleted cause of dea	th (Item 23a) (7) pe,	Print) CC	0	(/ 2	1 - 20	MD 20602
F	B5			(Amounto	50 (05	t other	MON	7 # 504	WALDOUT	My 20602
	Sta Registr		31. Date filed (Month, Day, Year) FFR 0 9	32. Reflistrar	s Signature	passes				

			1 - For State Registrar	State of M	arylan	d / Depa	artment of F rtificate of	lealth an Death	d Mental Hy	Reg. No.	004	
1	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Cora 4a. Fecility Name (If not institution, second)	Lewis			4b. City, Town, o	r Location of D	2. Date of De Februa	ry Day,	2004 unty of Deeth	3. Time of Death 8:25P M
- 9	Funeral		Genesis Elder 5. Social Security Number	Care	ge (In yrs. I	ast birthday) Yrs.		Plata If Under 24	Hrs. 8. Date of Bi		O Dist	rles Dace (State or Foreign Trginia
- 10-1	Director		225-16-1895 Usual Residence of Decedent 10a. State 10b. County	-X	99 10c. City	, Town or Lo	ocation		April	4,19		10d. Inside City Limits
	th the Mary or 28a-f sh e notified	Irector	MD Cha	ırles		La	Plata 10f. Zip Code			10g. Citizen	of Whal Cou	YYes 2 □ No
020	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	One Magnolia 11. Marital Status 1 Never Married 2 Marrie X Widowed 4 Divorced	12. Was Decedent Armed Forçes?	Ever in U. ? No			646 dispanic Origin an, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	0- 14.	USA Race - Americ Black, White, ecify: B	
0-012121	led within 72 hoi lygiene. her than *natur: nt, the Medical in	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of d)	working Name (First, Middle			_{dustry} aurant
ylaiid	should be filled Mental H marked off umatic ever	To Be	17. Father's Name (First, Middle, La Robert Wood 19a. Informant's Name/Relationship			19b Maili	ng Address (Street	Masze		ebste	r	a Code)
E, Ma	d 2 g		Jean Donley/S			15		k Poin	t Rd. No	ewbur		20664
Dalillio	t. Page ntment o ntant: If njury or		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Service Li	ecity)		1y G1	nost Cer	netery	2/12/0 LS FUNE	Isst	ue,Mai	ryland
ă	permi Depa Impo any is		23a. Part1. Enter the disease, or co	nry one cause on each i	ine.	n. Do not en	P.O. B.(er the mode of dyin	OX 567 ng, such as car	LA PLAT	RAL HO	2064	Approximate Interval Between Onset and Death
0,007	The law requires that the death certificate be executed that the attending physician and the been signed by the attending physician and the burial-transit to 2 should be detached for use as the burial-transit.	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the conditions of t	a. Due to (or as b. Due to (or as c. Due to (or as d.	s a consequ	uence of):	eart Fa					1 Wk
O. BOX O	the death certific y the attending p iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregnanc	y		23d.	Date of delive	ery Day Year
ecords, P.	quires that in signed b uld be deta	þ	Part II. Other significant condition Lupus Arthr	_	but not resi	ulting in the u	nderlying cause giv	ven in Part I.				he cause of death? pably 4\tilde{\trilee}\tilde{\ti
	The law requires that the ate has been signed by the page 2 should be detache	Completed	Failure to Anemia	Thrive					24a. Was	ormed?	4b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
VII	artifica ctor.	Be	25. Was case referred to medical examiner?						Death (Check only	one)		
ō	ding Physician: The I h. After this certificate ha funeral director, page	၉	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga			ER/Outpatie 28b. Time o Injury	f 28c. Inju		ng Home 5 Res 28d. Describe			(y)
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of In	ijury - At ho tc. <i>(Specif</i>)	ome, farm, st	reet, factory, office			(Street and Nown, State)	umber or Rura	al Route Number,
	To the Hospital of within 24 hours aft To the Funeral Discompletely filled it	edical	(Check only 2 Madical E	Physician: To the best xaminer: On the basis of and manner s	of examina		vestigation, in my	opinion, death		, date and pla	ice, and due t	o the cause(s)
	with to con	×	29b. Signature and title of certifier 30. Name and address of person w	1	dogth /les	2201 (7:	D444				igned (Month, 9 / 2004	
1	163 Sta	ate	Ash in Kumar 31. Date filed (Month, Day, Year)	Patel.M.D	. 10 trar's Signa	2 Pat	1 Mello	on Ct.	Waldorf	, MD 2	20602	
	Registi		FFB 1 0	2004	148	K L	berte					

State of Maryland / Department of Health and Mental Hygiene 2004 05514 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 8, Lula Dee McPeak 2004 5:30 a M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 630 Arch Street Residence: Perryville Cecil If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🖺 F 10,1913 213-38-8109 90 Yrs. North Carolina Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Example must be notified at 1X Yes 2 ☐ No Cecil Directo Maryland Perryville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21903 U.S.A. 630 Arch Street Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: δ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Eight Years Personal Residence Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. Burel E. Anderson Sarah E. Holloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond J. McPeak, Jr. (son) P.O. Box 594, Perryville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Brookview Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 02/11/04 Rising Sun, Maryland 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service Licensee Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** acuto my caud /Medical Due to (or as a consequence of): Examiner VHD Saventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit I V resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, by Physician/Medical ed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No 1 ☐ Yes 1 Yes 2 🔯 No Division of Vital ieral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🙀 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct
completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Du cee No no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jui-ChipHsu 223 W Main 31. Date filed (Month, Day, Year) FEB 1 0 2004 32. Registrar's Signat State Registrar

		1	For State Registrar	State of Maryla	and / Depa <i>Cer</i>	rtment of <i>tificate of</i>	Health and I f <i>Death</i>		giene 20 Reg. No.	04	05515
			Decedent's Name (First, Middle, Last)					2. Date of De. Month	ath Day	Yeer	3. Time of Death
	Physicia		Alice E. McCall					Februar			10:15am ^M
	/Medic Examin	a	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town,	or Location of Deat		4c. County	of Death	
	LAditiii		Sun Bridge Care and	l Rehahilita	tion Cer	nter	E1kton		Ce	ci1	
	Funoral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Yea	r If Under 24 Hrs	8. Date of Bir (Month, Da	th		lace (Stete or Foreign try)
	Funeral Director		218-18-5112	M 2X0F 9	5 Yrs.	Months Days	s Hours Min.	Februar		08 1	Maryland
			Usual Residence of Decedent								
	ylang		10a. State 10b. County	10c.	City, Town or Los	cation				1	Od. Inside City Limits
	Mar Mar	호	Maryland Ceci:	1	North	East					1 X ∑Wyes 2 ☐ No
	1 the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
	death with the Maryland ims 23e or 28a-f show if mart be notified at		104 West Walnut St:	reet		219	901		United	Sta	tes
	deat ms ?	Funerai		12. Was Decedent Ever in Armed Forces?	1 U.S. 13. V	Vas Decedent of	Hispanic Origin? (Suban, Mexican, Puer	specify Yes or No	- 14. Rac	e - Americ	
0	after or Its		1 Never Married 2 Married	1 ☐ Yes 2 🕅 No If Yes, Give		☐ Yes 21 N				. Whi	
3	ralf,	by	3 X Widowed 4 ☐ Divorced	Year or Dates:							
2	filed within 72 hours after Hygiene. kther than "netural", or Ite ont, I're Maylical Exuraliza	Completed	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Deced (Give	lent's Usual Occ kind of work don	upation le during most of wo red)	rking	16b. Kind of Bu	usiness/Ind	dustry
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V	or th	LO Co	6		Packe	er	1		Elkton		rkler
/land	m - 0 =	Be	17. Father's Name (First, Middle, Last)						, Maiden Suman	10)	
<u>a</u>	should be and Mental I		John Baker					et Reyno			
Mar	2 sho and is ma		19a. Informant's Name/Relationship (Ty	rpe, Print)			et and Number or R				
	5 # 7 F		Allen B. McCall/So	n			er Road, N				
Je,	of Head		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	200	b. Place of Dispo cemetery, cren orth East	sition (Name of natory or other p	laçe) - Febi	cuary 5,	20c. Location -	City or 10	own, Stete
Бащто	permit. Pages 1 Department of H Importent: If ite eny injury or of		4 □Donation 5 □Other (Specify)	NC	Cemetery		200)4			Maryland
	mit. partn porte / inju	. 1	21. Signature of Funeral Privile Lie in	e /	22	. Name and Add	tress of Facility C1	couch Fu	neral Ho	me	
ñ	Per E Co		166641	12cm	12	7 South	Main Stre	eet, Nor	th East,	Mar	yland 21901
	-		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the d	leath. Do not ent	er the mode of d	lying, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final	Interm	Fitial	Lung	Diseas	0			Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a con	sequence of):	-	70 20(3				
	Examiner			Cardio	MUOP	athu	•				
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	sequence of):	,	Λ				
	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Corona	iru A	rteru	1 Vide	9 Se			
	exect n and al-tra	Exa	resulting in death) Last	Due to (or as a con	sequence of):	11	100				
8760	icate be executed physician and s the burial-transit	dicail		Conge	stive	Hear	t fail	ure			
89	ficate pphy s the	0					\	·			
	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/M	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	gnancy	70			23d. Da	te of delive	
Box	atte	ciai	in the past 12 months? 1 Yes 2 No	1□Live birth 2□F 4□Pregnant at time]Ectopic pregnal] Other (s <i>pecify)</i>			Mo	onth	Day Year
o.	the d / the ched	iysi	9 ☐ Unknown	9□ Unknown							
٥.,	res that igned by	4	Part If. Other significent conditions co	ntributing to death but not	resulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use con	tribute to t	ne cause of death?
ds	sign d be	d by	Hupertentio	n				1 🗆	Yes 2 No	3 🗌 Prot	pably 4 □Unknown
Division of Vital Records,	w require been sig	Completed	AI DIG	rillation)			24a. Was	an 24b.	Were auto	psy findings available
ec ec	elaw hasl	idu	AWIAI FIO	111191101	1			auto	DSV .	prior to co death?	mpletion of cause of
<u></u>	: Th	S						1 ☐ Yes		1 🗌 Yes	2. No
ij	sician: The law certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		17	Othor	eath Check onl		-	
=	Physi this c	ည	TU Tes 2 NO	1 🗆 Impatient	2 ER/Outpatier	it 3 DOA	4 Nursing		idence 6 Oth how injury occur		(y)
Ē	ng P	on:	27. Manner of Death 1 ■ Naturaf 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o Injury		njury at Vork?	Zou. Describe	now infully occur	160	
<u>8</u>	eath. or: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be				☐ Yes 2 ☐ No	204 Location	Ctroat and Numi	har ar Our	al Route Number,
₫	r Ati ter d irect	E	4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At nome, farm, sti o <i>ecify)</i>	reet, factory, offic	СӨ		own, State)	Jer Or Hure	i riodio ranibor,
Ω	itel o			<u> </u>				}			
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only 2 Medical Exem	sician: To the best of my iner: On the basis of exar	knowledge, deat mination and/or in	n occurred at the vestigation, in m	e time, date and place by opinion, death occ	e, and due to the curred at the time	cause(s) and m , date and place,	anner as s and due t	o the cause(s)
	the lin 2.	led	one)	and manner stated.			ense number		29d. Date signe		
	To To	Σ	29b. Signature and title of certifier	.0		1	5977 2		r /		- 11
			1 TVIZ TV Co	covery		D.	0 1 (6)	<u>'</u>	rebruaru	1 41	2004
	20		30. Name and address of person who co		(Item 23a) (Type,	Print)	140		,	′	
_	20		138 Cathedral	Street.	Elkt	Dn.	MD				
		ate	31. Date filed (Month, Day, Year)	32. Registrar's S		P					
	Regist	rar	FFR 0.4 2004	How. P. K	Sneet	J.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05516 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yeer **Physician** 11:34a M Moore February 5 2004 Patricia Ann /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Port Republic
Under 1 Year Of Under 24 Hrs. 4050 Hance Road Calvert 8. Date of Birth (Month, Dey, Yeer) Nov. 11,1934 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 69 Pennsylvania Director 579_42_4587 Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County show rai', or items 23a or 28a-f show 1 ☐ Yes 2 🛛 No Maryland Calvert Port Republic Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20676 U.S.A. 4050 Hance Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 100 home maker own home 7 is marked other traumatic avant, I 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Miller Andrew Phillips Sadie 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2. Department of Heelth at Important; If item 27 is any injury or other trat once. 4050 Hance Rd., Port Republic, MD 20676 Massey Moore, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State

Other (Specify) So. Memorial Gardens | 02/09/2004 Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Port Republic, MD20676 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of) Examiner 107-2551VC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 14 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

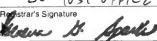
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 033123 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Lowenthal, M.D. 110 Hospital Rd. #310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registra Signature State Beneva. 06 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene n 1

	•	For State Registrar				,	Cei	tificate of I	Death		Re	g. No.	004	000	1 /
Physici	an	1. Decedent's Name			N T						Date of Deatl Month	Dave	Year	3. Time of D	eath
/Medic Examin	al	BARBARA H	f not institution			or)		4b. City, Town, or			EBRUARY	4c. Co	04 ounty of Death RLFS	5:10A	IVI
Funeral Director		9810 ANGE 5. Social Security N 577-44-4886		6. Sex 1 □ M	2 T F	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, RCH 31,	Year)	9. Birth	place (State or I	Foreign
ש		Usual Residence of	Decedent 10b, County			10c Cit	y, Town or La	ecation						10d. Inside City	Limits
farylar	5	MD	CHARLES				E PLAIN							T X TYes 2	
the N	Director	10e. Street and Nu			-	METT	IL ILM	10f. Zip Code			10	g. Citize	n of What Cou	ntry?	
h with	ai Di	9810 ANGEL	A DRIVE					20695			Į	NITE	STATES		
s within 72 hours after death with the Maryland Jiene. r than "naturel", or Items 23a or 28s-f show the Medical Examiner must be incitified at	by Funeral	11. Marital Status t ☐ Never Marr			Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	s?]No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Orig an, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No- an, etc.)		Race - Ameri Black, White,	etc.	
within 72 ho ene. than "natur the Wedical	Completed		15. Decedent	t's Educat	ion ompleted) College (1-4d	Nr. 5+\	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most	of working		16b. Kind	of Business/In	ndustry	
	mo	Elementary/Seco	oridary (0-12)		College (1-40		BUILDI	NG SERVICE					COVERNME	NT	
be filed ital Hygi id other event, t	Be	17. Father's Name		Last)							irst, Middle, M		ımame)		
	2	19a. Informant's N		hip /Tuge	Print)		19b Mailir	ng Address (Street			BS TURNI		own. State. Zii	p Code)	
is is		MARCELLA R						NGELA DRIVE					om, o .e.o, e.,		
of Health item 27 other tr		20a. Method of Dis	position				Place of Dispo	osition (Name of matory or other place	-	Date	-		tion - City or T	own, State	
		1 ♣ Burial 2 1 4 □ Donation	☐ Cremation 5 ☐ Other (Si		noval from Sta	TA I	AN COLLIN	TIONAL CEME	TERY (CO, VIRG	INIA	
permit. Page Department Importent: If any injury o		21. Signature of Fu	C. THORN	ION JC				Name and Addre					0640		
The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires the death certificate be executed The law requirements the death certificate be executed as the law requirements the death certificate because the death cer	Medical Examiner	shock, or hea Immediate Cause disease or conditive resulting in death) Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or that initiated event resulting in death)	onditions, mediate erlying injury s	b. c. d.	Due to (or	n line.	TIVE quence of):	HEART CARDOLO						Approximate Interval Betwo Onset and De	en e
res that the death certifi igned by the attending be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	months?	230	. If yes, outcor 1□Live birth 4□Pregnan 9□Unknowr	1 2 ☐ Feta t at time of c	al death 3	□Ectopic pregnancy □ Other (specify)	4			23	d. Date of deliv Month		ear
uires that the signed by the detaction is the detaction in the detaction in the detaction in the signer in the sig	by	Part II. Other signi	ficant condition	ons contr	- 1/	h but not res	sulting in the u	inderlying cause giv	en in Part I.			acco use		the cause of de	ath?
The law requir ste has been s	Completed										24a. Was a autops perform	n y ned?	24b. Were autreprior to condeath?	opsy findings at ompletion of car	vailable use of
ician: Th certificate rector, pag	BeC	25. Was case refe examiner?	rred to medica					0.11		of Death (C	heck only on	e)			
Physic this co	10	1 ☐ Yes 2 🔀	No	Ho			ER/Outpatie		4 🗆 1901		5 Reside		Other (Speci	ify)	
Attending Physician: It death. actor: After this certifice by the funeral director, i	tion	27. Manner of Dea 1 Natural 2 ☐ Accident	5 Pendir investi		28a. Date of I (Month,	Day Year)	Injury	Wor	rk? Yes 2□↑		. 50301150 110	,	50001100		
or Attending after death. Director: After in by the funer	Certification:	3 Suicide 4 Homicide	iome, farm, st fy)	, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)					Θ <i>Γ</i> ,						
Hospite 4 hours Funeret ely filled	edical C														
To the within 2 To the Complet	Me	29b. Signature and	d tille of pertifie	or				29c. Licens				29d. Date signed (Month, Day, Year)			
		•	Ville	Μ	ク				153	8885		2	10/2	-004	
12		30. Name and add			pleted cause	of death (Ite	m 28a) (Type,	Print)	COAD	#13	04	WAR	DORF 1	us 201	502

State Registrar

31. Date filed (Month, Day, Year) FEB 1 1 2004



State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Reg. No.	2004 05518								
	Physicia			2. Dete of Deeth February 5,	3. Time of Death 7:05PM								
>	/Medica Examine	4a Fecility Neme (If not institution, give street end number)		r Location of Death 4c. Cou	nty of Death								
	Funeral	Charles County Nursing Rehalt 5. Social Security Number 6. Sex 7. Age (In yrs. last b.			Charles 9. Birthplace (State or Foreign								
	Director	577-46-2929 1\\ M \ 2□F 70	Yrs. Months Days Hours Min	s. B. Date of Birth Month, Day, Year)	3 Washington D								
	show the day	10a. State 10b. County 10c. City, Tov	vn or Location		10d. Inside City Limits								
	the Mg 28m-fs noriffe	MD Charles Waldo	Orf 10f. Zip Code	10g Citizon	1 ☐ Yes 2 ☑ No of What Country?								
	ter death with the Maryler ferms 23s or 28s-1 show fret must be notified at	26 Mooncoin Circle	20602	USA									
020	irs af	3 ☐ Widowed 4 ☐ Divorced fi Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		Race - American Indian, Black, White, etc. City: White								
15-0	n 72 ha	15. Decedent's Education 16a (Specity only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of willfe. DO NOT use retired)	orking 16b. Kind of	Business/Industry								
212	d with	Elementery/Secondary (0-12) College (1-4or 5+) 12	Manager		enience Store								
Maryland 21215-0020	d 2 should be filad th and Mental Hygi 7 Is marked other traumatic event, I	17. Father's Neme (First, Middle, Last) Edwin Henry Newmeyer		ame (First, Middle, Maiden Sum e Fee Nevill									
Mar	d 2 sho th and 7 is me traume	19a. Informant's Name/Relationship (Type, Print)	D. Mailing Address (Street and Number or F										
ore,	permit. Peges i an Department of Haali mportant: if item 2 any injury or other ance.	20a. Method of Disposition 20b. Place of correction	1208 Leesville B1 of Disposition (Name of ory, crematory or other place)		n - City or Town, State								
	permit. Peges Department of I Important: If Its any Injury or o once.	4 Donation 5 Other (Specify) Brins	field-Echols FH	2/6/04 Char1	otte Hall,MD								
Ba	permit. Departr Imports any Inji	21. Signature of Funeral Service Licensee M00945	22. Name and Address of Facility AREHART-ECHOL P.O. BOX 567	S FUNERAL HO	ME,P.A.								
de la	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death								
A. C.	Physician /Medical Examiner	Immediate Cause (Final disease or condition	Failury										
	1	resulting in death) a. Due to (or es e		1									
	rifficate be executed ng physician and set the buriel-transit	Sequentially list conditions, b. Multiple Due to (or as a	consequence of):	<i>y</i>									
68760,	rifficate be executed ng physician and set the buriel-transit Medical Examin	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events											
89	eath certificate be executed ettending physician and for use as the bunel-transit clan/Medical Examir		consequence of):		1								
Bo	v raquiras that the death ce been signed by the ettendi should be detached for use letted by Physician/	d.											
0	at the cart he day the etached	Part II. Other significant conditions contributing to deeth but not resulting in	i the underlying cause given in Part I.	1 ☐ Yes 2 No	contribute to the cause of death? 3 Probably 4 Unknown								
ds,	uras th signed ild be d			24a. Was an autopsy	24b. Were autopsy findings								
000	S 25 0			performed?	available prior to completion of cause of death?								
<u> </u>				1L/Yes 2L X 90	1 ☐ Yes 2 ☐ No								
<u> </u>	his certified of director	25. Was case referred to medical examiner? 1 ☐ Yes 2 ⅓No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	Other:	ath <i>(Check only one)</i> Home 5 ☐ Residence 6 ☐ 0	ther (Specify)								
ם ב	oning Pnysician: The light After this certificate ha funeral director, page fullen: To Be Com	27. Magher of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Dey Year) 28b. 7	Firme of 28c. Injury at Work?	28d. Describe how injury occi									
	r Attendent ter deat rector: by the	2 Accident investigation 3 □ Suicide 6 □ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No rm, street, factory, office	28f. Location (Street and Nun City or Town, State)	nber or Rural Route Number,								
	within 24 hours of To the Funeral Di completaly filled in Medical Cer												
	within 24 To the F complete	one) and manner stated. 29b. Signature and title of certifier	29c. License number		ed (Month, Day, Year)								
	- ≱ ⊨ ŏ	James Charring MD	000 52919	2/6	104								
5	7 K21	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)		20646								
D) 0° l State	James I. Harring, M.D. 102 Ce 31. Date filed (Month, Day, Year) 32. Registrer's Signeture	ntennial Street,	Suite 102 L	a Plata, MD								
	Devictor	EED 0 0 2004 Kg . M	Acres 11 to										

Amend Item #1 State of Mandand Deperation of Mediting and Mental Hygiene 2004 05519 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** KATHERINE ANNA OTT 0220 08 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SNOW HILL NURSING CENTER SNOW HILL WORCESTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Oay, Year) 09 30 1912 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2🎇 F 91 Yrs. MICHÍGAN Director 224-62-8343 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Madical Examiner must be multiped at 1 Yes 2 No Director VIRGINIA ACCOMACK GREENBACKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3351 CAPTAIN'S CORRIDOR 23356 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: U.S. ARMY Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: WHITE ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL NURSF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be for and Mental F CHRISTOPH EUGENE OTT MARGARET HOWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m eny injury or other traum WILBUR BOWDEN/NEPHEW- Friend 3256 HIGH SEA DR., GREENBACKVILLE, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SALISBURY CREMATORY 02/09/04 ' 4 ☐ Donation 5 ☐ Other (Specify) SALISBURY, MARYLAND 21. Signature of Funeral S 22. Name and Address of Facility WILLIAMS FUNERAL HOME, 25046 PARKSLEY RD., PARKSLEY, VA23421 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy this certificate has been signed by the atteral director, page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending Pl
 A hours after death.
 Funeral Director: After ti Certification: 1-XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours at To the Funeral D 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 30 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05520 Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) FEBRÜARY IÖ 2004 **Physician** 9:30 A JAMES HOWARD PETERSON /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 10515 Willets Crossing Road Charles White Plains If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral 1**X** M 2□ F Feb 11 1956 Director <u> 212-72-3433</u> 47 Washington, DC Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-1 show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Items 23a or 28a-1 ehov eny injury or other traumatic event, Ite Medical Examinat must be notified at 1 ☐ Yes 2 ☐ No Maryland Charles Directo White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20695 USA 10515 Willets Crossing Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Evelyn Alvey Peterson 2 Andrew H. Peterson 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2791 Shiloh Church Rd Bryans Road, MD 20616 Evelyn A. Peterson (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 2-11-04 Alexandria, VA • 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Eberwein Funeral Services 21. Signature of F Feral Stree Licensee M00173 4433 White Pls. la. White Pls., MD 20695 . 2011. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm riate Cause (Final disease or condition recolling in death) Physician schemic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last petus) ac Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1.☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Munknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has 1 Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: Yes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier Tagovri MO D0050883 2-10-04 and address of person who completed cause of death (Item 23a) (Type, Print) POBOX 507 25500 POINT LOUISVIT DE LEWISKUTURIN 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2 0 0 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 07 2004 Physician HELEN LOUISE PRINCE 4:20 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. | 20, 1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mississippi **Funeral** 1 □ M 2 X F 71 Yrs. Director 216-54-6237 Usual Residence of Decedent with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mentai Hygiene.
Important: If item 27 is marked other than "natural", or itama 23a or 28a-f ahow amy injury or other traumatic event, the Medical Examinat must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Directo Maryland 1 ☐ Yes 27 No Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 127 Grant Street 21001 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 17/6 4 4 2 2 2 5-0036 Itimore, Maryland 21215-0036 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Salesperson Commissary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Issac McIntyre Ludie Curb ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harmer Prince / husband 127 Grant Street, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. James United Cem 2/13/04 Havre de Grace, MD 22. Name and Address of Facility
Lisa Scott Funeral Home, P.A. 21. Signature of Funeral Service Licensee scott 552 Lewis Street, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COLITIS **Physician** 1SCHEMIC DAYS /Medical Due to (or as a consequence of): Examiner SEVERE ATHEROSCLEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burief-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à PEUMONIA 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown PERIPHERAL VACOULAR DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? CHRONE RENAL FAILURE 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl. one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Polatural death. 1 ☐ Yes 2 ☐ No i or Attend efter death Director: / 2 Accident 6 Could not be 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours of To the Funeral completely filled Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) en Novalingle mo D08096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 125 N. MATN ST. BER AIR, MO21014 ANDREW NOWAKINSKI MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 11 Agrands FEB 1 0 2004 DHMH 17 Rev 1/2001

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Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 23e or 28e-1 ehow eny injury or other traumatic event, the Modical Examinar must be notified at once.

Pnysician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the buriat-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Please 1	Type or Print in Blac									
1 - For State Registrar	State of Maryland / D	Department of He Certificate of D	alth and M eath	lental Hygie		05522				
1. Decedent's Name (First, Middle, Last, Samuel J	Petras			2. Date of Death January	8ªY, 2004	3. Time of Death				
4a. Fecility Name (If not institution, give 10505 Cedarville F		4b. City, Town, or L Brandyw			4c. County of Death					
5. Social Security Number 086-30-7558 Usuel Residence of Decedent	384 005	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Aug. 15		nplece (State or Foreig untry) New York				
10a. State 10b. County Maryland Prince	10c. City, Town	n or Location andywine				10d. Inside City Limit				
10e, Street and Number 10505 Cedarville		10f. Zip Code 20613		10g	Citizen of What Co	untry?				
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Norced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Ves. 2 □ No 1961— If Yes, Give Year or Dates: 1965	13. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2X No	panic Origin? (Spe Mexican, Puerto I Specify:	ectly Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	o, etc.				
15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th	de completed) College (1-4or 5+)	Decedent's Usual Occupati (Give kind of work done du- life. DO NOT use retired)		ng	b. Kind of Business/I	,				
17. Father's Name (First, Middle, Last)	<u> </u>		8. Mother's Name	(First, Middle, Ma	U.S. Gove: iden Sumame)	rnment.				
Samuel J. Petras			Helen Si							
19a. Informant's Name/Relationship (T) Daniel D. Petra	,, ,	. Mailing Address <i>(Street an</i> 5675 Valley F								
20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery Cheltenha										
21. Signature of Funeral Service Ucens L. (1)	TE MB 490	22. Name and Address 6633 Old Al								
23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Intracere brown	hematrha	2	or respiratory arrest		Approximate Interval Between Onset and Death				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence									
Cause (Disease or injury that initiated events resulting in death) Last	c									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliment	very Day Year				
Part II. Other significent conditions co	ntributing to death but not resulting in	n the underlying cause given	in Part I.		co use contribute to	2				
				24a. Was an autopsy performe	prior to c	topsy findings availa ompletion of cause of				
25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	Other		(Check only one)	0.13(0)) (0	At sce				
1XX Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b.	Time of 28c. Injury a Work?	4 Nursing Hot	28d. Describe how	e 6 (X Other (Specinjury occurred	ny) At Sec.				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, street, factory, office	1	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,				
	vsician: To the best of my knowledge iner: On the basis of examination an and manner stated.									
29b. Signature and title of certifier		29c. License r	number	29d.	Date signed (Month	, Day, Year)				
I had had	m, P	O.C.M	.E.	Fe	bruary 01	, 2004				

State Registrar

31. Date filed (Month, Day, Year) FEB 1 0 2004

LING

MID 32. Restrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

d Mental Hygiene 2004 05523

State Registrar	Certificate of Death
For	State of Maryland / Department of Health and

			Registrar				Cei	rtificat	te of i	Death	7		Reg. No.		
19	Physici	an	1. Decedent's Name (First, Midd		i also w	1	T-4					2. Date of D Month		Year	3. Time of Death
,	/Media	cal	Howard D			a1,	Jr.	41 11				Feb:	ruary 3	-	7:04 AM
	Examir	ıer	4a. Facility Name (If not institution Ft. Washington		_	ster				Location shine				nty of Death	eorge's
	Funaral		5. Social Security Number	6. Sex		e (In yrs. las	t birthday)		r 1 Year		r 24 Hrs.	8 Date of B			
	Funeral Director		214-08-1055	1 □ X /1 2 □	10	33	Yrs.	Months		Hours		(Month, D	rth ay, Year) 4,197(Mar	place (State or Foreign ntry) vland
	P .		Usual Residence of Decedent						l	l.				Jilai	yrana
	irylar how	_	10a. State 10b. County			10c. City, 7	Town or Lo	cation						1	0d. Inside City Limits
	Ba-f	ç	Maryland Cha	rles		B:	ryan	s Ro	ad						1 ☐ Yes 2 🌠 No
	ith th	Dire	10e. Street and Number					10f. Zij	Code				10g. Citizen o	f What Cour	ntry?
	ath v	a	6765 Amherst							516				S.A.	
	ltem Item	Funeral Directo	11. Marital Status	Arm∈	Decedent E		13. \	Was Dece f Yes, spe	dent of Hi cify Cuba	spanic Or n, Mexica	rigin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	o- 14. R B	ace - Americ lack, White,	
38	irs aff	by F	1 X Never Married 2 Mar 3 Widowed 4 Divorced	If Ye.	res 2. ∏N s. Give or Dates:	10		1 🗆 Yes	2 □ ₩o	Specify	:		Spec	eify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Examiter must be notified at	ted		nt's Education		1	16a. Deced	dent's Usu	al Occupa	ation			16b. Kind of		
212	hin 7	Completed	(Specify only highs Elementary/Secondary (0-12)		ted) ge (1-4or 5	+)	(Give lite. L	kind of wo	ork done d se retired	turing mos)	st of worki	ng			
2	od wil	Con	12		30 (1 101 0		C	arpe	nte	ר			Const	ruct	ion Co.
5	be file tal Hy d oth	Be (17. Father's Name (First, Middle,			-							, Maiden Sum	ame)	
yla	should tind Ment marked umatic	ပ္	Howard David	d Picke	eral,	Sr.				Ma	ry H	elen	Adams		
Maryland	2 sh and Is m		19a. Informant's Name/Relations										er, City or Tow		
	l and lealth om 27		Mary H. Picke	eral M	lothe		6/6	5 Am	hers	st R	d.,	Bryan	s Road	, Md	20616
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation		rom State	Met 1	e of Dispo: etery, cren CODO	sition (Nai patory or c	ne or other place	Feb	. 10	2004 Arvic	20c. Location	1 - City or To	wn, State
<u>=</u>	rtmer rtant rtant njury		* 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service			1.100.		-				CIVIC	Alex	andr	ıa, va.
Ba	Depa Impo eny i		21. Signature of Pulleral Service	Licenses	M	00668	Q W	. Name ar i l l i	nd Addres ams	Fun	eral	Home	. P.A.		20640
E,	3 -		23a, Part1, Enter the disease, o	r complications t			Do not ente	270	HAwt la of dving	hor	ne R	d., I	P.A.	Head.	Approximate
100		i o	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final	only one cause	on each line	θ.	101	2	1 Villa	y, 50011 a5	Cardiaco	respiratory a	11051,	1	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a		ult		- /	fu	VIE	2			-	
13	Examiner			Dui	e to (or as a	a consequen	ice of):								
20		e_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due	e to (or as a	consequen	ice of):								
	od d ansit	Examiner	cause (Disease of injury that initiated events	S .											
ó	certificate be executed iding physician and ise as the burial-transit		resulting in death) Last	Due Due	e to (or as a	consequen	ce of):								
68760	ate be nysici he bu	n/Medical		d											
9	h certific anding pl use as t	Med	IF FEMALE:					_							
Rox		lan/	23b. Was decedent pregnant in the past 12 months?	10L	ive birth 2	of pregnancy 2 🗌 Fetal de	ath 3	Ectopic pr	egnancy					ate of delive	-
	he de	Physicia	1 Yes 2 No		regnant at t Inknown	time of death	n 5 🗆	Other (sp	ecify)				1	iontri	Day Year
<u>.</u>	The law requires that the death te has been signed by the atter age 2 should be detached for u	P.	Part II. Other significant condition	ons contributing	to death bu	t not resultin	o in the un	derlying	ause auco	o in Part I		23a Did t	abacca usa co	stributa ta th	e cause of death?
Hecords,	sign d be	d by	•				g ar aro arr	idonying o	auso giva	iriiri qiri	*		Yes 2 No		ably 4 DUnknown
ö	w requir been si should	ete					·								
ĕ	The lav	Completed										24a. Was		prior to com	sy findings available apletion of cause of
Vital	(0 (7	င္ပ	GE Man annu referred to an dis-									12S.Yes	2 No	death?	2□ No
		o Be	25. Was case referred to medica examiner? 1√3√es 2 □ No	Ho spital:	I ☐ Inpatien		0		Othe			(Check only o		-	
Ö	y Physer this eral di	h	27. Manner of Death	28a. D	ate of Injury	/ 281	Outpatient b. Time of		8c. Injury	4 ∐ Nu	rsing Hom	ne 5 ☐ Resident 8d. Describe	dence 6 Ot	her <i>(Specify</i> , rred)
<u>_</u>	Attending ir death. ector: After by the funer	tiol	1 Natural 5 Pendin 2 Accident investi	9	Month, Day	Year)	Injury	M	8c. Injury Work' 1 ☐ Y	? es 2. X ∫			struck		2
UIVISION	or Attendi after death. Director: A in by the fu	iji	3 Suicide 6 Could	Z88. P	lace of Injur	rv - At home		et, factory	, office		2	8f. Location (Street and Num	ber or Rura/	Route Number,
5	tal or rs afte al Dir ed in	Certification;	Tomicae		инашу, өкс.	(Specify)	stre	et			R	oad A	vn, State) 179	009 C	Route Number,
	e Hospital or A 124 hours after e Funeral Direc letely filled in by		29a. Certifier 1 Certifyir (Check only 2XMedical	g Physician: To	the best of	f my knowled	dge, death	occurred	at the time	e, date an	d place, a	nd due to the	Cauca(c) and m	annor an etc	lod
	To the Hospital within 24 hours a To the Funeral completely filled	Medical			nanner state	ed.	ZITA OL INV				ar occurre	at the time,	uate and place	and due to	ine cause(s)
	or Will	~	29b. Signature and title of certifie		0 1	10.	,		. License				29d. Date sign	ed (Month, D	Day, Year)
				Ma		7			O.C.	M.E.			Februa	ry 4,	2004
Y	3 1		30. Name and address of person ZABILLL		cause of dea	ath (Item 23)	а) (Туре, Р		Donn	C+~	oot-	Ral+im	ore, Ma	rvl ard	1 21201
	Stat	e	31. Date filed (Month, Day, Year)	3	2. Røgistrar	's Signature		4		эщ	et,	DOTFIL	OLE, Md	r à raik	4 C1CV1
*	Registra	_	FEB 0	9 2004	AND	w l	K A	2210	,						

State of Maryland / Department of Health and Mental Hygiene 104 05524 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2004 Feb. Yeer **Physician** RATCLIFFE MOSES 6, 4:02 PM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) **Examiner** Civista Medical Center LaPlata, MD Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year | Min. | Dec. 11, 1 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F Dec. Virginia 75 Director 226-32-4057 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at another. 1 Yes 2 No Directo Waldorf MD Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20601 1801 Oak Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 MYes 2 □ No 1951
If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 N Widowed 4 □ Divorced Year or Dates: 1953 white Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cotlege (1-4or 5+) Elementary/Secondary (0-12) Lumber Yard Laborer 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amanda Fisher James Timple Ratcliffe 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter-Sixth Street, Indian Head, MD 20640 Dottie L. Ferrell-in-Taw 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gdns. 02-10-2004 Waldorf, Maryland Huntt Funeral Home
P.O. Box 156, Waldorf, MD 20604-0156

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC PULMONARY DISEBSE OBSTRACTIVE Physician 5 YRS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): .O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably ON GESTIVE HEART 1 ☐ Yes 2 ☐ No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an ormed? 2 ZNo 1 ☐ Yes 2 XNo 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 SNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D-28281 FEB. 8, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nelson V. Benjers, MD 6B Industrial Park Dr., Waldorf, MD 20602 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State FEB 0 9 2004 Registrar

Rateliffe,

			- FOI	Department of Health and Mental H Certificate of Death	ygiene 2004 0552
	6,		Decedent's Name (First, Middle, Last)	2. Date of D	Death 3. Time of Death
	Physici		Evelyn Simmons Smith	Februa	ary 9,2004 3:15A M
	/Medic Examin	discoult	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		Lijean.	Waldorf Health Care Center	Waldorf	Charles
1	Funeral Director		5. Social Security Number 228-18-8967 6. Sex 1 M 2 F 7. Age (In yrs. last bird)	Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of E (Month, I Nov. 1	Birth Pay, Year) 11, 1914 Virginia
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town		10d. Inside City Limits
	faryla show	ō		aldorf	1 ☐ Yes 2√2 No
	28e-1	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	3a or		4140 Old Washington Road	20602	U.S.A.
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-1 show La Mexical Existine treat be trofilled at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1 ☐ Yes 2X No Specify:	Specify: Black
8	tural		3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education 16a.	. Decedent's Usual Occupation	16b. Kind of Business/Industry
215	hin 72	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	
2	ygiene /giene er tha	Com	2	Homemaker	Home
nd	be filted that the potential of the pote	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	
Z	hould d Mer marke matic	ို	Jimmy Simmons 19a. Informant's Name/Relationship (Type, Print) 19b	Eugenia Ri	
S	nd 2 s lith an 27 is			368 Pembroke Dr. Manliu	
ē,	s i ar f Hea f Hem other	1. 3	20a. Method of Disposition 20b. Place of	f Disposition (Name of ry, crematory or other place)	20c. Location - City or Town, Stete
Ë	Page nent o int: If		1 Burial 2 Micromation 3 Linemoval from State	field-Echols Crematory	Charlotte Hall, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, Ite Medical Exaculate must be rediffed at ance.		21. Signature of Funeral Service Licensee M00817	Arehart-Echols Funera P.O. Box 567 La Plata	al Home, P.A.
r.			23a. Pert1. Enter the disease, or complications that caused the death. Do n	IP.U. BOX 56 / La Plata not enter the mode of dying, such as cardiac or respiratory	arrest. Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	VE HEART FAIL	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence)	VE HEART PAILL OI): EROTIC HEART DIX	200
	Examiner		Sequentially list conditions, if any, leading to immediate b. ATLCRUSC In to Due to (or as a consequence of the consequence of	ERUTIC HEART DIX	THE MICH
	ed sit	ulne	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury	or):	
	execunate and al-train	Examlner	that initiated events c. Due to (or as a consequence	of):	
8760,	cate be executed oblysician and the burial-transit	call	d		
9	ng ph	Physiclan/Medical	IF FEMALE:		
Box	eath certific attending p for use as f	lan/l	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome or pregnancy 1 Live birth 2 Fetal death		23d. Date of delivery Month Day Year
o.	that the deed by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 ☐ Other (specify)	
۵.	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as it.	by Ph	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I. 23e. Did	d tobacco use contribute to the cause of death?
Division of Vital Records,	w requires that s been signed to should be det	ed b	FAILURE TO THRIVE	10	Yes 2 No 3 Probably 4 Unknown
eco	has be ge 2 sho	Completed	CHRONIC RENAL IN	She fice Early 24a. We au	tonsy prior to completion of cause of
<u> </u>	The cate h page	Corr	l	per 1 □ Yes	rformed? death?
Vita	ician: Th certificate rector, pag	Be	25. Was case reterred to medical examiner?	26. Place of Death (Check only	
5	Phys r this ral dir	1: To	27. Manner of Death 28a. Date of Injury 28b. 1	Itpatient 3 DOA 21 Nursing Home 5 He	sidence 6 Other (Specify) e how injury occurred
on	Attending Physician: ir death. ector: After this certification of the funeral director.	atlor		Injury Work? M 1 □ Yes 2 □ No	
VIS	l or Attendate after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	irm, street, factory, office 28f. Location City or 7	(Street and Number or Rural Route Number, own, State)
Õ	urs after rel Dir				
	To the Hospitel or Atlanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Check only one Check one Check only one Check only one Check only one Check one C	e, death occurred at the time, date and place, and due to thind/or investigation, in my opinion, death occurred at the time	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
	To the within To the Youth	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			> 1/ 49 aly	D44436	FEB 09 2004
1	10		30. Name and address of person who completed cause of death Item 23a)	(Type, Print)	CT WALDORFMD2860Z
	DOI		ASHVIN KUMAR JATEL 31. Date filed (Month, Day, Year) 32. Refistrar's Signature	M) 1027AMMellon	CI WALDORING DE 602
	Sta Registi		FEB 1 1 2004	Sperke	

Amend Item 10g par FH G828 02/25/0/dibbartment of Health and Mental Hygien 2004 05526 1 - State Amend Item#7perFHG828 2/21/04 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 10, 2004 **Physician** 5:30 A M Caecilie Johanna Spoerl /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9815 Tam-O- Shanter Drive Upper Marlboro Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, May 12, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2/2XF Ĩ915 219 08 8404 83 Germany Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28e-f ehow Examinar must be notified at 1 □Yes 2 □ No Directo Upper Marlboro Maryland Prince George's 10g. Citizen of What Country? Germany 10e. Street and Number ö 238 9815 Tam-O- Shanter Drive 20772 United Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No tryes, Given X Year or Dates: 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: δ 3√ Widowed 4 □ Divorced White "natural" ar than "nature I'm Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental important: If item 27 is marked o any injury or other traumatic eve once. Pillhofer Johann Koh1 Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9815 Tam-O-Shanter Drive, Upper Marlboro, MD 20772 Gerda E. Brown (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State February 11, 1 Burial XX Cremation 3 □Removal from State Lee Crematory * 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 22. Name and Address of Facility Lee Funeral HOme, Inc 6633 Old 21. Signature of Funeral Service Licens Alexandria Ferry Road, Clinton Maryland 20735 M00542 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ONGESTIVE **Physician** /Medical Due to (or as a consequence of) Examiner ILATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions conjubuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ENM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⊠Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospitel or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 154 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title 29c. License number 2004 3885 30. Name/and address of person who completed cause of death (Item 23a) (Type, Print) (COAD ENICAT. 1501 AM AWAN 31. Date filed (Month, Day, Year) State 11 2004 FEB Registrar

Box 68760,

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Division of Vital Records,

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of H	ealth and Mental Hygiene 2 ft O I

05527 Department of Health and Mental Hygiene UUL Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** JAMES EDWARD SWAILES FEB 2004 :58 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) Examiner LAPLATA

| Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
| Worth, Day CIVISTA MEDICAL CENTER CHARLES 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1**X** M 2 ☐ F 79 SEPTEMBER 15,1924 MARYLAND 218-16-2580 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show to builtied at least at 1 ☐ Yes 2X No Funeral Director MARYLAND CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3508 CRAKE COURT 20640 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puento Rican, etc.) Race - American Indian, Black, White, etc. or items 11. Marital Status traumatic event, the Medical Exeminer 1 Never Married 2 Married 1 Tyes 2 No 1 ☐ Yes 2 【No Specify: Specify: Be Completed by BLACK 3 Widowed 4 □ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other than College (1-4or 5+) HEAVY EQUIPMENT OPERATOR CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES MADISON SWAILES MARTHA ELIZABETH GWYNN SWAILES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra once. JAMES A. SWAILES / SON 3508 CRAKE COURT, INDIAN HEAD, MARYLAND 20640 20a. Method of Disposition

1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY FEBRUARY13, 2004 CLINTON, MARYLAND 21. Signiture of Funeral Service Vicenses THORNION FUNERAL HOME, P.A LYDIA C. THORNION JOHNSON MOOS83 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transit that the death certificate be executed resulting in death) Last physician Physician/Medical as the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year for 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 TYes 2 🕢 No use 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DQA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 ANatural 1 Yes 2 No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature at 29c. License number 29d. Date signed (Month, Day, Year) of 6, 2004 well relakel /hmo D-0008370 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL E. PRITCHET MD118 LAGRANGE AVE. P.O. BOX 1317 LAPLATA, MD 31. Date liled (Month, Day, Year) State FFB 1 0 2004 Registrar

			= State Amend Item #5	per 11 6831 5/2	\$/04 ta	ertifica	te of L	eaith and it Death	nemainy	Reg. No.	2004	03320	
			Decedent's Name (First, Middle, Last						2. Date of De			3. Time of Death	
	Physicia /Medic	al .	Edna Virgini)eMoss				FEB.	7,	2004	0610 A M	
	Examin	er	4a. Fecility Name (If not institution, give 6016 ALLENTOWN F					Location of Death HILLS			County of Death RINCE GE	ORGES	
	Funeral Director		5. Social Security Number 6. S 210 03 6084 1 210-03-5984 Usual Residence of Decedent		yrs. last birtho 32 Yrs	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month Da Dec 18	y, Yaari	9. Birth Mary	place (Stete or Foreign nly) Tand	
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits	
	Pa-f st	ctor	Maryland Prince G	eorge's		Clint						1 □ Yes 2 V No	
	death with the Maryland rms 23a or 28a-f show rmst be notified at	i Directo	10e. Street and Number 8123 Woodyard R	load			p Code .0735		4		izen <i>o</i> f What Cou .ited Sta	-	
	death	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was Dec	edent of Hi	spanic Origin? (Sr n, Mexican, Puerto	pecify Yes or No Rican, etc.)		14. Race - Ameri Black, White	can Indian,	
Maryland 21215-0036	be filed within 72 hours after death with the Marylar Ital Hygiene. d other then "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 □ Nøver Married 2 □ Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give AX Year or Dates:		1 🗆 Yes		Specify:			_	White	
קל	"natu	Completed	15. Decedent's Ed (Specify only highest gra	fucation ide completed)	16a. D	ecedent's Us Give kind of wife. DO NOT	ual Occupa ork done d use retired	ition furing most of work	king	16b. Ki	ind of Business/Ir	ndustry	
717	be filed within 72 tal Hygiene. d other than "nateworl, the Western	ошо	Elementary/Secondary (0-12)	College (1-4or 5+) 4		ecurit					US Airfo	rce	
פ	al Hyg J othe	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nam			Sumame)		
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Z Z	d 2 sh th and th and t7 Is II		JoAnn V. Grimes (,	nd Number or Ru oods Driv		-		MD 20659	
ē,	item	1	20a. Mathod of Disposition	21						20c. Lo	ocation - City or T	own, Stete	
Ē	Page ment c ant: If ury or		1 ♣ unial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	(Y)	Marylan				1			Maryland	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		21. Signature of Funeral Service Licer	201 MO137	4	Alexa	and Addres andria	s of Facility Lee a Ferry R	Funera	1 Ho into	ome, Inc	6633 01d land 20735	
	*		23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atheros cleratic Cardia Vasuular disease or condition										
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	d			ovas	iular o	siseas	l			
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_			IF FEMALE:										
Box	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	23c. If yes, outcome of printing the second o	Fetel death	3 □Ectopic 5 □ Other (23d. Date of delive Month	ery Day Year	
P.O.	hat the od by the detach	Phy	9 ☐ Unknown Part II, Other significant conditions of		t resulting in t	he underlying	cause give	on in Part I.	23e. Did t	obacco ı	use contribute to	the cause of death?	
rds,	quires that the de n signed by the a uld be detached f	d by							10	Yes 2	□No 3□Pro	bably 4 Unknown	
O O	ie law requ has been je 2 should	Completed							24a. Was	an	24b. Were aut	opsy findings available ompletion of cause of	
ž		Com							perfo	rmed? 2 ☐ No	death?	2 No	
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outp	ationt 3□ f	Othe	26. Place of Dea			eVV that /Sag	AT CCENE	
0	g Phys er this eral di	-	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Tin	ne of	28c. Injury	at Nursing n	ome 5 ☐ Resi 28d. Describe			(v) AT SCENE	
SION	endin sath. or: Aft	atio	1 Natural 5 Pending investigation	n		M		res 2 □ No					
Division of Vital Records,	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifics tely filled in by the funeral director, I	Certification:	3 Suicide 6 Could not b 4 Homicide determined		At home, farm pecify)	n, street, facto	ory, office		28f. Location (City or To			al Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (nysician: To the best of miner: On the basis of exa and manner stated.									
	To the h within 24 To the F complete	Me	29b. Signature and title of certifier			2	9c. License				te signed (Month,	Day, Year) 2004	
				. m.D						11			
(DB ID		30. Name and address of person who				eet,	Baltimor	re, Mary	land	21201		
	Sta		31. Date filed (Month, Day, Year) FFR 1 0	32. Reinstrar's	Signature	bou	ريا						

State of Maryland / Department of Health and Mental Hygiene 2 1 1 L 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** 14:54 M 04 Mary Louise /Medical 4a, Facility Name (In not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince 9. Birthplace (State or Foreign Country) Clinton Maryland Hospital Douthurn If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 68 Director February 16,1935 Maryland 213-44-6792 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County itam 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examiner must be notified at 1 □X es 2 □ No Brandywine Maryland Prince Georges Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20613 16906 Magruders Ferry Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Domestic 12 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) yland should be fi Be Ε Greenfield Savoy Sr. Mary Α James 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health and Mai permit. Pages 1 and 2.
Department of Health a Important: if item 27 is any injury or other trau Pages 1 and 2 2531 Robinson Pl Waldorf, Maryland 20602 Mary Lyles/ Grand-Daughter نه 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State Date 20a. Method of Disposition Baltimor 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Peters Cath Ch Cem 2/9/04 Waldorf, Maryland 4 Donation 5 Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licensee OHel Mussa MO1323 Adams Funeral Home P.A. Aquasco, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician oronary UNKNOWA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď eq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No a funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) ₹ examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 PER/Outpatient 2 1 Inpatient 3 DOA Division of After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and fille of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5817 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 6705 Village Park DK. Greenbelt, MD 31. Date filed (Mon State 2004 Registrar

Amend #26 per Doctor, Assisted Living, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 2/11/04, drw 05530 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 1 6:08 p 2004 Estelle Rebecca Trott /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Esther's Place Assisted Living Baltimore 8. Date of Birth (Month, Day, Yeer) 9. Birthplece (Stellar Country) Sep. 14, 1912 Maryland If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplece (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2QF 91 214-01-1112 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State or 28a-f show r than "natural", or Items 23a or 28a-f show the Medical Examples must be notified at 1 Yes 2 □ No Director Baltimore n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Žip Code 21214 **USA** 2802 Pinewood Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ white 3 NWidowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 should be filed withir h and Mental Hygiene. I is marked other than College (1-4or 5+) 12 clerk department store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental important: If item 27 is marked sny injury or other traumatic sv ORR! Sadie Rebecca 2 Joseph Gibson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 993 Clay Hammond Road, Prince Frederick, MD 20678 Cheryl Ann Harms, great-niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 02-04-04 Huntingtown, MD Miranda Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility William 20736 Rausch Funeral Home, P.A., Owings, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Hlyacarda /Medical Due to (or as a consequence of): **Examiner** carchovascular disease Arreviosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. physician for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 3 ☐ Probably 4 ☐ Unknown 2 XNo 1 Tes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No certificate

Division of Vital Records, Attending Physician: Japital co. 74 hours after dec. 1 real Director: № fo the within 24 hours at to the Funeral Director To t

ΙĐ

director,

this funeral

Aller

Certification: To

Medical

31. Date filed (Month, Day, Year) State FEB

25. Was case referred to medical

29b. Signature and itle of certifier

5 Pending

investigation 6 Could not be determined

1 Yes 2 No

27. Manner of Feath

Natural 2 Accident

3 Suicide

29a. Certifier (Check only

4 | Homicide

MD 4594 32. Registra Signature

Hospitaf: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Yeer)

and manner stated.

30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

3 DOA

28c. Injury at Work?

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicef Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

36246

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living

Beaverbrook Rd. Columbia MD Z1044

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Assisted

Registrar

MIO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05531 1 - For Stete Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** February 7, 2004 2:13 A Mable Evelyn Taylor-Rauch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert County 1031 Lower Marlboro Road Huntingtown If Under 1 Year | If Under 24 Hrs. Birthplace (Stete or Foreign Country) Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Months Days Hours 1 □ M 2X F 76 234-38-6234 Director Nov 16 1927 W<u>est Virginia</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County "natural", or items 23a or 28a-f show or other traumatic event, it is Medical Exercitive must be notified at 1 ☐ Yes 2 XNo Directo Calvert Huntingtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1031 Lower Marlboro Road 20639 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gearheart Acey Ethel McLaughlin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun Daniel Rauch (husband) 1031 Lower Marlboro Road Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Feb 10 1 ▼Bunal 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Resurrection Cem. Clinton, MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Runeral Service Licensee

Physician /Medical

within 72 hours after

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

Examiner

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

	Gary J. G	off	8125 Sc	outhern Mary	land Blvd.	Owings,	MD 20736
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused the death. It cause on each line.				Minora	Approximate Interval Between Onset and Death
	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent to (or as a consequent to conse	ce of):	UN. C 065	D, SCASC		
	Cooking in doubly cast	d	ice or).				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel de 4 Pregnant at time of death 9 Unknown	ath 3 Ectopic pr			23d. Date of deli Month	very Day Year
	Part II. Other significant conditions or	ontributing to death but not resultin	ng in the underlying ca	ause given in Part I.	23e. Did tobacco		the cause of death?
					24a. Was an autopsy performed?	death?	topsy findings availab completion of cause of 2 No
	25. Was case referred to medical			26. Place of De	ath (Check only one)		
)	examiner? 1 Ves 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3 □ DO	Other: 4 Nursing H	Home 5 Residence	6 □Other (Spec	rify)
	27. Manner of Death 1. Adatural 5 Pending 2 Accident investigation	(Month, Day Year)	Bb. Time of 2 Injury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory	r, office	28f. Location (Street a City or Town, Sta		ral Route Number,
	29a. Certifier 12 Certifying Ph	ysician: To the best of my knowle	edge, death occurred	at the time, date and place	e, and due to the cause(s) and manner as	stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and planner stated.

29c. License number

10845 Town Center Blvd., Dunkirk, Maryland 20754

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

15

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause

Jonathan D. Lowenthal,

of death (Item 23a) (Type, Print)

M.D.

2004

32. Registras Signature

EDWARD I. WIRSHIP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / [State Registrar	Department of Health and Me Certificate of Death	ental Hygiene 2004 0553
Physician /Medical	Decedent's Name (First, Middle, Last) Edward J. Win		2. Date of Death Month Day Year EBRURRY 7 2004 0403
Examiner	4a. Pacility Name (If not institution, give street and number) Leninsula Regional Medical Cest 5. Social Security Number 7. Age (In yrs. last bir	4b. City, Toym, or Location of Death Splisbury	4c. County of Death Wicomico
uneral irector	076-05-4204 12 M 2 □ F 98 Usual Residence of Decedent	Months Days Hours Min.	B. Date of Birth (Month, Day, Year) 0/23/1905 Birthplace (State or Fore Country) Maryland
a-f show filled at	10a. State 10b. County 10c. City, Tow	n or Location ncess Anne	10d. Inside City Lim 1 ☐ Yes 2
be netified Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Important: If item 27 is marked other then "natural", or items 23e or 28e-f show sny injury or other traumatic event, it is Medical Exacting mast be notified at once. To Be Completed by Funeral Director	13439 Harrison Landing Road 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 3 Never Ne	21853 13. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri	Specific
t, its Medical Ex Completed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Com		Sales Engineer	Design Sales First, Middle, Maiden Sumame)
To Be	Alvin A. Winship	Rose Simm	
jury or other trau	Edward J. Winship, Jr./Son 13 20a. Method of Disposition 20b. Place of cemeter. **ABurial 2 Cremation 3 Removal from State 120 Donation 5 Other (Specify) Mt. 0	ivet Cemetery 02/10/	2004 Frederick, Maryland
ician	27. Signature of Funeral Parvice/Licensee AMON AMON AMON AMON AMON AMON AMON AMON		Princess Anne, MD 21853 Approximate Interval Between Onset and Death
attending prysicion and for use as the burial-transit and consideration and consider	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Due to (or as a consequence d.	Anty De	to yr
Dhyslcian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
be c	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow
C4 D			24a. Was an autopsy performed?
I director	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: ☐ Inpatient 2 ☐ ER/Ou	26. Place of Death (0 patient 3 DOA Other: 4 Nursing Home	Check only one) 5 □ Residence 6 □ Other (Specify)
to the Funstel Director: Attenthis certificate in completely filled in by the funeral director, page Medical Certification; To Be Com	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year)		d. Describe how injury occurred
lled in by	4 Homicide determined building, etc. (Specify)		Location (Street and Number or Rural Route Number, City or Town, State)
completely filled Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	Vor investigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)
Com	29b. Signature and title of certified	29c. License number 2644/	29d. Date signed (Month, Day, Year) 2/01/2004 SALISWY, M.D
	30. Name and address perso, who completed cause of death (Item 23a)	Type, Print)	- /, /

		•	For State Registrar		State of	of Maryla		artment of ertificate o			•	giene Reg. No. 2	2004	05533
			Decedent's Nam	e (First, Middle,	Last)						2. Date of De.	ath		3. Time of Death
	Physici /Medi		Willian	n Howard	l Ayres						Febru	Day	7 2 004	8:16A M
	Examir	ner	4a. Facility Name (If not institution,	give street and nu		4	4b. City, Town	, or Location	of Death			unty of Death	
			Frankli		uare	HOSP.	tal	Ros				Bo		more
	Funeral		5. Social Security N		6. Sex 1 ⊠ M 2 □ F		s. last birthda 7 Yrs.	y) If Under 1 Yea Months Day		Min.	8. Date of Bird (Month, Da 03/08/	th y, Year)	Coun	
	Director		219-32-8 Usual Residence of		21	67	113.				03/08/	1936	Mary	land
	/land		10a. State	10b. County		10c. (City, Town or	Location					1	0d. Inside City Limits
	Man,	ģ	MD	Balt	imore		Baltim	ore						1 ☐ Yes 2√2 No
	th the	lrec	10e. Street and Nu	mber				10f. Zip Code	•			10g. Citizer	of What Cour	ntry?
	ours after death with the Maryland rat' or items 23s or 28s-f show Examiner man by modified at	by Funeral Director	1027 Cd	old Spri	ng Road			21220)			U.S	.A.	
		ruei	11. Marital Status		Armed F		U.S. 13	. Was Decedent of If Yes, specify Co	f Hispanic C uban, Mexica	origin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White,	
36	hours after tural', or ite	y F	1 ☐ Never Marr 3 ☐ Widowed		d 1 X Yes If Yes, G		958-	1 ☐ Yes 2 💢 N	lo Specif	y:		Sp	ecify:	
9	within 72 hours ene. then "natural", ha Medical Exi	ed to	2 - 44100#80	15. Decedent's	Year or I	19	16a Dec	edent's Usual Occ	unation			16b Kind	Whi of Business/Inc	
~R	within 72 ane. then "na	Completed		cify only highest	grade completed,		(Gi	re kind of work don DO NOT use reti	ne durina mo	ost of work	king	100.11.10		200,
' 9 5	filed with Hygiene. ther the	mo	Elementary/Seco	ondary (U-12)	4	(1-4or 5+)	Ch	airman			Į.	Varfie	ld-Rohi	Casket Co.
pc	e filed al Hygi other vent, I	Be C	17. Father's Name	(First, Middle, L	ast)				18. Mot	her's Nam	e (First, Middle,	Maiden Su	mame)	
<u>a</u>	should band and Ments in marked	10	William	Lewis A	Ayres				Ir	ma Ma	arie Noi	r		
W. III or M Maryland 21215-0036	ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If Item 27 is marked other then "natur or other treumatic event, The Medical	1 3	19a. Informant's N					iling Address (Stre						Code)
-	and lealth m 27				es (wife)			027 Cold		-	7127797			21220
or o	ges 1 au t of Hea if item or othe		20a. Method of Dis 1 XBurial 2		3 🗌 Removal from	1 State		position (Name of ematory or other p	1		Date		tion - City or To	
ly (e)	artmen ortant: injury		° 4 □ Donation			0.		n Cemetei		THE RESERVE	1/2004			, Maryland
ABal	permit. Pages Department of I Important: If it eny injury or o		21. Signature of Fu	101 ACB	Scho Ch			22. Na <i>m</i> e and Add						l Home, P.A. 21087
			23a. Part1. Enter to shock, or hea	the disasse, or o	complications that	sed the de	eth. Do not e	nter the mode of d	lying, such a	s cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause disease or condition	on	alerke	rioscha	vatic	cerarary	artes	rude	care			Onset and Death
	/Medical Examiner		resulting in death)		Due to	o (or as a cons	-	(1				
	Lxanime		Sequentially list co	onditions,	b									
	sit ed	Examiner	cause. Enter Under Cause (Disease or	erlying	Due to	o (or as a cons	equance of):						- 1	
	and and Il-tran	хап	that initiated event: resulting in death)	S	c	o (or as a cons	equence of):							
8760,	ate be executed thysician and the burial-transit					, , , , , , , , , , , , , , , , , , , ,	- 1							
687	the the	dic			d	_								
Вох	The law requires that the death certificate has been signed by the attending propage 2 should be detached for use as:	Physician/Medical	IF FEMALE: 23b. Was deceder	nt pregnant		utcome of preg		_				23d	. Date of delive	ery
	death a atte d for	cia	in the past 12	months?	4□Preg	birth 2 ☐ Fe gnant at time o		□Ectopic pregnai □ Other (s <i>pecify)</i>					Month	Day Year
P.0.	at the de by the a tached	hys	9 Unknown		9□ Unki	nown								
ώ.	res tha igned be det	by P	Part II. Other signi	ficant condition	ns contributing to	death but not r	esulting in the	underlying cause	given in Par	t 1.	23e. Did t	obacco use	contribute to th	ne cause of death?
rd	w require been sig should b	ed	#12	dake	u Lyn	ngran	70				1 🗀 '	Yes 2 1	No 3□Prob	ably 4 Nnknown
၁၁	e taw re has be	piet		0	0	V					24a. Was	an 2	4b. Were auto	psy findings available impletion of cause of
<u> </u>		Completed									perfo	rmed?	death?	
ita	Attending Physician: Th r death. sctor: After this certificate by the funeral director, pag	Be	25. Was case reference	rred to medical					26. Pla	ce of Deat	th (Check anly o			
>	Physic this ce ral dire	2	1 Tyes 2					OUT DON		Nursing Ho	ome 5 ☐ Resid	dence 6	Other (Specify	y)
n o	ding P h. After t funera	on:	27. Manner of Dea 1 Avatural	th 5 ☐ Pending	28a. Date (Mo	e of Injury nth, Day Year)	28b. Time Injun	V			28d. Describe I	how injury o	ccurred	
sio	uttendi death. ctor: A y the fu	cati	2 ☐ Accident 3 ☐ Suicide	investig 6 ☐ Could n	ot he		.1		Yes 2]No	006 1	-		
Division of Vital Records,	P digital	Certification:	4 Homicide	determi	200. Plac	ding, etc. (Spe	nome, tarm, cify)	street, factory, offic	8		City or To	street and N wn, State)	lumber or Hura	l Route Number,
4	To the Hospitel or At within 24 hours after of the Funerel Direct completely filled in by		29a. Certifier	10 Cartifying	Physician: To th	ne best of my k	nowledge, de	ath occurred at the	time, date a	and place,	and due to the	cause(s) an	d manner as st	tated.
	in 24 he Fu	Medicai	(Check only one)	2 Medical b	xaminer: On the and ma	nner stated.	nation and/or	investigation, in m	y opinion, de	eath occur	red at the time,	date and pla	ace, and due to	the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and	title of certifier	/				nse numbe				igned (Month,	Day, Year)
	/X\		> /ho	non K	enalu	lur	11)	/	12/0	22		2-1	17.04	
	15		30. Name and add	ress of person v	vho completed cau	-9.	-	e, Print)	1230	right.	1111 7	2 2		
	1,5		31. Date filed (Mor	oth Day Year)	10/1	Registrar's Sig	nature.	1/2 /00/	1275	40	M1) 21	0).		
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			For	State of Maryla	ind / Departme	ent of Health and I	Mental Hygier	1e 2 11 11 L	05534
			Registrar		Certifica	ile oi Dealii	Reg. N	lo.	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle,	A	tan		Month E	ay Year	1:20 PM
	/Medic	A. Carlotte	4a. Facility Name (If not institution,			ty, Town, or Location of Deatl		c. County of Death	7
	Examin		Baltimore Richardi					NA	
	Funeral				rs. last birthday) If Uni	der 1 Year If Under 24 Hrs.		9. Birthr	lace (State or Foreign
	Director	Į	216-52-4114	100 M 2□F	55 yrs. Month	s Days Hours Min.	May 30, 1.	948 N.C	arolina
	P .		Usual Residence of Decedent		O - T		1 1		Od India Ob Links
	show		10a. State 10b. County	1.0	City, Town or Location			'	0d. Inside City Limits 1 Yes 2 □ No
	8a-f	cto	/VI) /V	/// L	BALTIMORE			(14)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23a or 28a-f show any righty or other traumatic event, the Medical Examination is used to apprece	Funeral Director	10e. Street and Number	nd St.	101.	Zip Code 21230	109.	Citizen of What Could	ntry ?
	ams	Iner	11. Marital Status	12. Was Decedent Ever in Armed Forces? 1 (2) Yes 2 ☐ No	U.S. 13. Was De If Yes, s	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	ean Indian, etc.,
36	or It	by Fu	1 Never Married 2 Marrie	1 Des 2 No If Yes, Give Year or Dates: / 96	9-1973 1□ Yes	2 No Specify:		Specify: Bla	ck
ö	hours ural',	q p	3 ☐ Widowed 4 ☑ Divorced		1	I Convention	105	Kind of Business/In	duction
5-	nat	lete	15. Decedent's (Specify only highest	grade completed)	16a. Decedent's U (Give kind of	sual Occupation work done during most of wol Tuse retired)	rking	Kind of Business/in	oustry
12	withi ene. then	Completed	Elementary/Secondary (0-12)	College (1-4gr.5+)	Cook	,	F	totel	
9	filled Hygi other		17. Father's Name (First, Middle, La	ist)		18_Mother's Nar	ne (First, Middle, Maid	en Sumame)	
an	ld be ental ked c	To Be	Wilson Hrong	ton		Cherry	1 Harv-	e y	
7	shound M	-	19a, Informant's Name/Relationshi	(Type, Print)	19b. Mailing Addre	ess (Street and Number or Ru	ıral Route Number, Cit	Town, State, Zip	Code)
Ž	t and 2 Health a tem 27 la		Kimita Hrr	inaton - claug	htir 1160 1	cleveland St	- Balto.	MD 216	30
J. C.	of He of He item		20a. Method of Disposition		p. Place of Disposition (/	lame of rother place)	Date 20c.	Location - City or To	own, State
Ĕ	Pages nent of t ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control of the Contr	ocity)	arrison For	est VA d-a	20-040u	ings Mi	IS MD
Baltimore, Maryland 21215-0036	permit. Departr Importe any inju		21. Signature of Funeral Service Li	consee	22. Name	and Address of Facility	- 11 11	0 0	
	90 = 90		Start (1 11)	nel	Gary 1	Williarch Ith a	Hornochiltur	Truss Din	LOVID SINAS
E				omplications that caused the de nly one cause on each line.	eath. Do not enter the m	ode of dying, such as cardia	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediale Cause (Final disease condition	-a. Hepm	tocellula	- Carcin	Jona		Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as a tions	sequence of):				
		<u>.</u>	Sequentially list conditions,	b. Due to (or as a cons	equence of):				
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11	be executed sician and burial-transit	хаг	that initiated events resulting in death) Last	c Due to (or as a cons	equence of):				
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68	ne death certificate the attending phys thed for use as the	edi							-
ŏ	n cert andin use	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fo		pregnancy		23d. Date of delive	
ω.	deatl	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of				Month	Day Year
Ö.	that the de ed by the detached	Physician/Medic	9 🗆 Unknown				-		
s,	res that the signed by to be detach	by	Part II. Other significant condition	s contributing to death but not a	resulting in the underlyin	g cause given in Part I.		o use contribute to the	
ord	w require been si should l	ted			· · · · · · · · · · · · · · · · · · ·		1 Yes	No 3 Proc	ably 4 Unknown
ec	law ras be	Completed					24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
= E	eicien: The law s certificate has b lirector, page 2 s	Con					performed 1 ☐ Yes ———————————————————————————————————		2 No
/ita	cien: ertific ector,	Be	25. Was case referred to medical examiner?	Heavitel.		100	ath (Check only one)		
£	hyei this c	P	1 Yes 2 No		ER/Outpatient 3		fome 5 Residence		y)
n c	ding Phyon. After this funeral di	lon:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	lury occurred	
Sign	death.	icat	2 Accident investiga 3 Suicide 6 Could no	t be gee Gleen of Injury A	t home, farm, street, fac		28f. Location (Street	and Number or Russ	al Route Number
Division of Vital Records, P.O. Box 687	after Direction by	Certification:	4 Homicide determin	building, etc. (Spe	ecify)	ory, omos	City or Town, Sta		
_	spital ours ours filled		29a. Certifier Certifying	Physician: To the best of my i	mowledge, death occum	ed at the time, date and place	, and due to the cause	(s) and manner as s	tated.
	To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical E	kaminer: On the basis of exam and manner stated.	ination and/or investigat	ion, in my opinion, death occu	irred at the time, date a	nd place, and due to	the cause(s)
	To th To th sompl	Me	29b. Signature and title of certifier	11		29c. Licensa number	29d. [Date signed (Month,	Day, Year)
	· CK		1000	Holen		00055035	5 2	112/04	
	The		30. Name and address of person w	ho completed cause of death (I	tem 23a) (Type, Print)	^			
_	E.		Lynn Hallarman	, M.P. 3900	Loch Rav	: O Bonlevark	Solting	~ MD	21218
	Sta	ate	31. Date filed (Month, Day, Year)	B 2 1 32 Registrar's S	hature	P			

		1	For State Registrar	State of Ma	ryland /	Departme Certifica			Mental Hyg	jiene jeg. No. 2	001	05535
	Physician	1	1. Decedent's Name (First, Middle, L Baby Girl Buck						2. Date of Dea Month Februo	th		3. Time of Death
	/Medica Examine Funeral Director	r	4a. Facility Name (If not institution, graft of the Sq. was 5. Social Security Number 6.	ive street and number)	ital	Ro	5 ec	If Under 24 Hrs Hours Min. 2	h	40. Co	1 mo	h
	D		Usuel Residence of Decedent 10a. State 10b. County MD		10c. City, To	wn or Location Baltimon	re	2 37	100 10,	2004	mary	10d. Inside City Limits 1 ∑ Yes 2 □ No
	death with the Maryland ms 23e or 28e-f show mind be notified at	Funeral Director	10e. Street and Number 2323 E. Preston	Street		10f. Z	Sip Code	213			of What Co	untry?
980	after or its	by Funera	11. Marital Status 1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:				dispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14.	Race - Ame Black, White	
21215-0036	within 72 hours after iene. then "netural", or ite	Completed by	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) none		+)	ia. Decedent's Us (Give kind of w life. DO NOT	work done	during most of wo		16b. Kind	of Business/	Industry
Maryland 21	2 should be filed within and Mental Hygiene is marked other than aumatic avent, ITS N	10 Be	17. Father's Name (First, Middle, Las John Holt 19a. Informant's Name/Relationship		10	Rh Mailing Addre	ss /Straat	Dani	me (First, Middle, Lelle Buc ural Route Numbe,	Maiden Sui kner		Tin Code)
_	s 1 and 2 s f Health an item 27 is other traur		Franklin Square 20a. Method of Disposition	Hospital	20b. Place		nklin	n Square	Drive, B	altim		MD 21237
なべてい Baltimore,	permit. Pages Department of Important: If it any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Special Service Lice Lice Lice Lice Lice Lice Lice L	ensee	ctor				d 655 W.	Ralt-	imore	Street
0,	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Se vere	e Prena consequence	e of):	ode of dyir	ng, such as cardia	OI c or respiratory an	est,		Approximate Interval Between Onset and Death
P.O. Box 68760,	ath certificate itending phy or use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	2 Fetel dea	th 3 Ectopic 5 Other (,		23d	. Date of del	ivery Day Year
ds, P.	w requires that the de been signed by the a should be detached f	٥	Part II. Dther significent conditions	contributing to death bu	ut not resulting	g in the underlying	cause giv	en in Part I.	23e. Did to	/		the cause of death?
Division of Vital Records,	stcian: The law rec certificate has bee irector, page 2 sho	Completed							24a. Was a autop: perfor	SV	prior to death?	topsy findings available completion of cause of
Vita	stcian: certifica irector,	Re	25. Was case reterred to medical examiner?	Hospital:			Ott	OF.	ath (Check only or			
ion of	nding Phys tth. :: After this s funeral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of Injur (Month, Day	ry 28b	Outpatient 3 0 Time of Injury M	28c. Injur Wor	y at	dome 5 Resid			cify)
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification;	3 Suicide 6 Could not 4 Homicide determine		ury - At home, c. (Specify)	farm, street, facto	ory, office		28f. Location (S City or Tow		umber or Ru	ıral Route Number,
	the Hospi nin 24 hou the Funer	Medical	(Check only 2 Medicel Ex one)	Physician: To the best of aminer: On the basis of and manner sta	examination atted.	and/or investigation	on, in my o	opinion, death occi	urred at the time, o	date and pla	ce, and due	to the cause(s)
	with To Corr	2	29b. Signature and title of certifier	and	(AU)	P	9c. Licens	0600	F	ebru	ary i	B 2004
_			30 Name and address of person who	19000 frank	eath (Item 23a	(Type, Print)	Pri	re Ba	Hinore	MP,	3/3	37
	Stat		31. Date filed (Month, Day, Year)	32/ Registra	ar's Signature	And to						

			4 101	partment of Health and Mertificate of Death		ne No. 2001	05536	
	Physici /Medic		Decedent's Name (First, Middle, Last) EDITH	BUGATCH	2. Date of Death Month FEBRUARY	^{Day} 19, 2004	3. Time of Death 2:15 A M	
	Examin	er	4a. Facility Name (If not institution, give street and number) KESWICK MULTI CARE CENTER	4b. City, Town, or Location of Death BALTIM If Under 1 Year If Under 24 Hrs.		4c. County of Death	N/A	
ر خهرا	Funeral Director		5. Social Security Number 220-03-9566 Colored Property Security	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye FEB.5, 19.	par) 9. Birth Cou	nplece (Stete or Foreign untry) VA	
	Maryland a-f show	tor	10a. State 10b. County 10c. City, Town or	Location LTIMORE			10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	h with the 23a or 28a	Funeral Director	10e. Street and Number 1840 REISTERSTOWN ROAD	10f. Zip Code 21208	10g.	Citizen of What Cou	U.S.A.	
036	be filed within 72 hours after death with the Maryland ital Hygiene of other then "natural", or items 23s or 28s-f show event, I'm Medical Exaction material be rediffed at	þ	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 W No If Yes Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto □ Yes 2 ♥ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	ican Indian,	
21215-0036	swithin 72 ho liene r than "natur the Medical I	Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0·12) College (1-4or 5+)	pedent's Usual Occupation re kind of work done during most of works DO NOT use retired) LESLADY	n <i>g</i>	TAIL LAD	IES APPAREL	
Maryland 2	should be filed and Mental Hygin marked othar matic event, I	To Be C	17. Father's Name (First, Middle, Last) JOSEPH LEADE	1,000	(First, Middle, Maid		POTASKY	
	and 2 s ealth ar m 27 is ner trau		ESTHER ROSENSTOCK / DAUGHTER 712	iling Address (Street and Number or Rura 1 PARK HEIGHTS AVEN	NUE #409 -	- BALTIMOR	RE, MD 21215	
Baltimore,	t. Pages 1 tment of H tant: if ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) BETH TFI	ematory or other place) LOH CEMETERY 2/20/	2004	WOODLAWN	, MD	
Ba	permit. Departi import. any inj		Death M. Cuttler	8900 REISTERSTOWN	ROAD - PI	ON & BROS. [KESVILLE,	MD 21208	
ď	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A C T S Due to (or as a consequence of): Sequentially list conditions,	evere Branch i Ling disease		'n	Approximate Interval Between Onset and Death NOUNS	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	•			U	
P.O. Box 6	that the death certificated by the attending placed for use as t	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year		
rds, P.	quires that in signed by uld be deta	Ď	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to t	the cause of death?	
al Records,	ysician: The law requir is certificate has been si director, page 2 should	Completed	,		24a. Was an autopsy performed 1 Yes 2	? prior to co	opsy findings available impletion of cause of	
Division of Vital	ding Ph	Certification: To Be	25. Was case referred to medical examiner? 1	of 28c. Injury at Work? M 1 Yes 2 No	ne 5 Residence 8d. Describe how in	6 ☐ Other (Special Special Sp		
Ö	i Dire	sai Certi	building, etc. (Specify) 29a. Certifier 12Certifying Physician: To the best of my knowledge de	ath occurred at the time, date and place,	City or Town, St	ate)	tatad	
,	To the Hospitel within 24 hours a vithin 24 hours completely filled	Medical	one) and manner stated.	29c License number	294 1	Date signed (Month	Day Yansi	
,	70		30. Name and address of person who completed cause of death (frem 23a) (Typ) W.A.R. (ey GBmc GZa) N.C	D25205 D25205 Apriles St. Lecto	. Md 2	20204		
	Sta Registr		31 Date filed (Month, Day, Year B 2 3 200 1 200 1	& species				

		•	1 - For State Registrer	State of Ma		artment of F ertificate of	lealth and Men Death	ital Hygie Reg.	71114	05537
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, DOROTHEA 4a. Facility Name (If not institution, HARFORD ME	M. CO	URTS	4b. City, Town, o		02	Day Year 2004 4c. County of Death	_
	Funeral Director		1 1 1 1 1 1		o (In yrs. last birthday 56 Yrs.	If Under 1 Year Months Days	Hours Min. (Date of Birth Month, Day, Ye UNE 27	ar) Coi	place (State or Foreign intry) HINGTON, D.C
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other then "natural, or tlams 23a or 28e-f show imetic event, the Medical Eventinal must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	12. Was Decedent If Armed Forces? 1 ☐ Yes 2 ☒ M If Yes, Give Year or Dates: s Education grade completed) College (1-4or 5 2 Yr S ast) MAN p (Type, Print)	Ever in U.S. 13. 16a. Decc (Given life) COO!	NGDON 10f. Zip Code 21 Was Decedent of H If Yes, specify Cub 1 Yes 2 X X Io edent's Usual Occup e kind of work done DO NOT use retire K	009 dispanic Origin? (Specify an, Mexican, Puerto Rica Specify: Deation during most of working d) 18. Mother's Name (Find DOROTHY Research and Number or Rural Ro	Yes or No- n, etc.) 16b C: rst, Middle, Maid OSE JOHI	Citizen of What Cou U.S.A. 14. Race - Amere Black, White Specify: BL . Kind of Business/I ITIZENS Aden Surname) NSON by or Town, State, Z	10d. Inside City Limits 1 □ Yes 2 丞 No untry? ican Indian, , etc. ACK industry ND APG
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tree		JONN COURTS/HU: 20a. Method of Disposition 1 □ Burial 2 ဩ Cremation '4 □ Donation 5 □ Other (Sp. 21. Sign in of Funeral Service L	3 □Removal from State ecify)	20b. Place of Disp cemetery, cre METRO C	osition (Name of ematory or other pla REMATORY 22. Name and Addre M. C. BROWN	02-24-	04 BZ		own, State MARYLAND FORD, P.A.
8760,	American and hysician and hysician and hysician and the buriar-fransit	dical Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CARDIA Due to (or as Due to (or as C.	e. ACAR1 a consequence of):	ZHYTHR		spiratory arrest,		Approximate Interval Between Onset and Death
O. Box 6	at the death certific by the attending pl tached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc	у		23d. Date of delik Month	very Day Year
of Vital Records, P.	e law requires tha has been signed je 2 should be de	Completed by Ph	Part II. Other significant condition	is contributing to death bi	ut not resulting in the	underlying cause gr		1 ☐ Yes 24a. Was an autopsy performed	24b. Were aut prior to co	opsy findings available ompletion of cause of
Division of Vital	tending Physiclen: leath. tor: After this certifice the funeral director, p	Certification: To Be Co	25. Was case referred examiner? 1 Yes 2 No 27. Mann r of Death 1 Natural 5 Pending investig: 1 Accident 6 Could in determined.	ation of be	y 28b. Time (Injury	of 28c. Injur	26. Place of Death (Cher. 4 In Nursing Home ry at 28d. k?) Yes 2 \(\subseteq No \)	5 Residence	6 ☐ Other (Specially occurred	
D	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical Cert	29a. Certifier 1 Certifying	Physician: To the best of xaminer: On the basis of and manner sta	of my knowledge, dea examination and/or in	th occurred at the tinnvestigation, in my o	me, date and place, and	due to the cause	e(s) and manner as	stated. to the cause(s)
	5		29b. Signature and title of certifier Jaum 97 30. Name and address of person w AWN M. K.C. 23. Data filed (Month Cary York)	NEDY-LITT	LE, DO	Print)	056010 MEMOR	2	Date signed (Month) 196 HOSP 17A	4
	Sta Regist		31. Date filed (Month, Day, Year)	2 3 2004 ×	Signature	fresh				

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day -Month Year **Physician** February Oseman 2004 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution give street and number) 4c. County of Death Examiner TOW500 North Charles St BARN Mare R 7001 If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 200F Days Hours Yrs. December 28,1946 Director 558-76-2586 Usual Residence of Decedent AZI FORNIA 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director MORE DALE 0 10g. Citizen of What Country? 10e. Street and Numbe U.S.A. 21237 128 ChesAco Pages 1 end 2 should be filed within 72 hours efter death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: ģ Whitp 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education
(Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN Secretary 124 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Correll Southware Melvin 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kriston Roach (daughter, Resedite 928 Chester 40 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of He Important: If Iten any Injury or oth once. 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arald Crevety 4 ☐ Donation 5 ☐ Other (Specify) 024 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 67 Fts Rushy Auston Correly HAVEN w Manita 7526 MR 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Physician/Medicai Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown roma þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No TO Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Medicai Certification: To 1 Yes 2 No 4☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Director: After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 4 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigetion death 2 Accident 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral D completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DZ3450 mo 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 5905 GHURCH 31. Date filed (Ma 3 Registrer's Signature State Registrar

DHMH 16 Rev 6/95

	_	-	State of Registrer	of Maryland / Dep	artment of H	ealth and M	ental Hygien	e 2004	05539
)	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) WALTER 4a. Facility Name (If not institution, give street and not be the facility Name (If not institution).		72	Location of Death	IN PRIVATE	18 2004 c. County of Death	3. Time of Death 53 M ATM
	Funeral Director		5. Social Security Number 6. Šex 1 1 X 2 F	7. Age (In yrs. last birthday 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea APR 30,19)	14 9. Birthple Country NEW	ce (State or Foreign
Maryland	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation LTIMORE				d. Inside City Limits 1 ☐ Yes 2√ No
di di di	23a or 28	Funeral Director	10e. Street and Number 1840 REISTERSTOWN RD.		10f. Zip Code 212	08	10g. (USA	y?
CU36 Pours after death with the Maryland	ral', or items 23a or 28a-f shov Exertifier rount be notified at	by Funer	Armed F	2 No ive	Was Decedent of H If Yes, specify Cuba 1 Yes No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americar Black, White, et Specify: WHI	tc.
-C121	than "nai the Medic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Specification (0-12) College (1-1)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired PROPRIETOR	during most of worki i)	ng	Kind of Business/Indu HOUSE SLIPI	PER
Maryland Z	ental Hygi ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last) MORRIS	CHWICK			(First, Middle, Maid EREBROWSK)		
	tra a		19a. Informant's Name/Relationship (Type, Print) SYLVIA CHWICK (WIFE)		ing Address (Street : 40 REISTE			or Town, State, Zip C RE, MD 212(
more,	ment of Heali ant: If item 2 lury or other		20a. Method of Disposition 1	State 20b. Place of Disp cemetery, cre BETH TF	ematory or other plac			Location - City or Tow	n, State
Baltimore,			21. Signature of Funeral Service Licensee	1.		ss of Facility SOL	LEVINSON	& BROS., :	
	hysician /Medical .xaminer	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		nter the mode of dyin	g, such as cardiac o	or respiratory arrest,	1	Approximate Interval Between Onset and Death
-	ttending phys	Completed by Physiclan/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, o	utcome of pregnancy birth 2 Fetal death 3 pnant at time of death 5	□Ectopic pregnancy	,		23d. Date of delivery Month D	y Day Year
ds, P	n signed by the a	d by P	Part fl. Other significant conditions contributing to MASS'UE PLEUSER F.	death but not resulting in the	underlying cause giv	en in Part I.	23e. Did tobacc	ouse contribute to the 2 ☑ No 3 ☐ Probal	e cause of death?
	cate has been si	Complete	DENENTIA CONO.	ABOTIS ME	Ellitus	line	24a. Was an autopsy performed 1 Yes 2	prior to com death?	sy findings available pletion of cause of
on of Vital	To the hospital or strenging Priystcian. The far within 24 burs after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	tlon; To Be	27. Manner of Death 1 Natural 5 Pending (Mo	npatient 2 ER/Outpaties of fnjury anth, Day Year)	of 28c. Injur Wor	er: 4 Nursing Ho	me 5 Residence 28d. Describe how in	6 □Other (Specify) jury occurred	
=	s after deat al Director: ad in by the	Certification;	3 Suicide 6 Could not be 28e. Place	ce of Injury - At home, farm, s ding, etc. <i>(Specify)</i>	street, factory, office		28f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
:	lo the hospital within 24 hours a To the Funeral C	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the 2 Medicaf Exeminer: On the and ma						
; •	vithin 2 To the complet	Me	29b. Signature and title of certifier	mo	29c. Licens		29d. I	Date signed (Month, D	ay, Year) 18, 2004
	10		30. Name and address of person who completed ca	use of death (Item 23a) (Type	e, Print) No	NALII CEO	of fearing	AC CER MYCHOLO	1200
	St Regist	ate rar		Registrar's Signature	H Anse	e i		-/	

	_		1 - For State Registrar	State of Maryla	and / Depa	artment of tificate o	Health and	d Mental Hyg	giene 20 (04 05540
>	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) Aa. Facility Name (If not institution, give s	Cline	. 1	4b. City, Town	, or Location of D	2. Date of Dea Month 02	Day Y	3. Time of Death OUY 700 PM Death
	Funeral Director		220 70 0710	M 20 F 7. Age (In y	rs. lasi birthday) 43 yrs.	If Under 1 Year Months Day	If Under 24 l	Hrs. 8. Date of Birth (Month, Day Dec 2,	Year) 9	. Birthplace (State or Foreign Country) Mary Land
	se Maryland	Director	Usuel Residence of Decedent 10a. State 10b. County MD N/A		City, Town or Lo	9				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
' 0	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Machal Examinar Induit by multified at ange.	Funeral Dire	10e. Street and Number 4802 Mannasota Ave 11. Maritat Status 1 ☑Never Married 2□ Married	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No	1	Yes, specify Ci	f Hispanic Origin? uban, Mexican, Pt	(Specify Yes or No-		•
Maryland 21215-0036	ithin 72 hours a le. Isn "natural", o	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12)	If Yes, Give Year or Dates: cation completed) College (1-4or 5+)	16a. Deced (Give life. L	OO NOT use reti	upation ne during most of	working	Specify: W 16b. Kind of Busin Construc	
yland 21	ould be filed w Mental Hygier tarkad other th	To Be Cor	8 17. Father's Name (First, Middle, Last) Charles Francis C		Paint		Madeli	Name (First, Middle, I ne Hilda 2	Zachman	
, Mar	and 2 sh lealth and m 27 is m		19a. Informant's Name/Relationship (Type Ms. Barb Cline/Sis	ster	9528	Perry H	all Blvd	Rural Route Number	gham, MD	21236
Baltimore,	nit. Pages 1 artment of H ortant: If Ite injury or ott B.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	amoval nom state	cernetery, cren Chesapea	ke Crem	atory	Feb 23 2004	20c. Location - Cit Beltsvil	le, MD
Ba	Depa Impo any is		Stale	ll Moc		8717 Gre	en Past	uneral Altures Drive	Baltime	ore, MD Approximate
760,	Physician /Medical Examiner	ıl Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):					Interval Between Onset and Death
O. Box 68	The law requires that the death certificate I tte has been signed by the attending physi page 2 should be detached for use as the t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3 [Ectopic pregnar Other (specify)			23d. Date o	f delivery Day Year
a	w requires that been signed b should be deta	by	Part II. Other significant conditions cont	tributing to death but not	resulting in the ur	nderlying cause	given in Part I.			te to the cause of death? Probably 4 Dunknown
al Records,		Completed							ned? prior deat	e autopsy findings available to completion of cause of th? Yes 2 No
Division of Vital	ding Phy n. After this funeral d	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatien 28b. Time of Injury	28c. in	ther: 4 Nursin	Death (Check only on g Home 5 ☐ Reside 28d. Describe ho		Specify)
Divis	or At ifter of Nirect in by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, streecify)	et, factory, offic	θ	28f. Location (St. City or Town		or Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	icien: To the best of my er: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the restigation, in my	time, date and play opinion, death o	ace, and due to the ca courred at the time, da	ause(s) and manne ate and place, and	or as stated. due to the cause(s)
•	To the within 2 To the complet	M	29b. Signature and title of certifier	extra MF)	Pi	6485		9d. Date signed (N 02 1 8	100 H 200 H
-	Sta	te	30. Name and address of person who con Nikki HA PessolA 31. Date filed (Month, Day, Year)	mpleted cause of death (I	2 500		reene '	Street Bo	Mimore,	NO 21201
	Registr		rep 9		ene. K	Social				

			State of Maryland / Depa	rtment of Health and M tificate of Death	ental Hygi	iene 2004	05541
	Physicia	an	1. Decedent's Name (First, Middle, Last) Martha L. Driver		2. Date of Death	Day Year	3. Time of Death
	/Medic Examin Funeral		4a. Facility Name (If not institution, give street and number) A A A A A A A A A A A A A A A A A A A	4b. City, Town, or Location of Death One of Death If Under 1 Year If Under 24 Hrs.	FEBRUAF 8. Date of Birth	4c. County of Death Some A	Se T
	Director		252-26-0901 1□M 2∏F 84 Yrs. Usual Residence of Decedent	Months Days Hours Min.	(Month, Day, Sept 1,	1919 Geoi	rgia
	Maryland f show	or	10a. State 10b. County 10c. City, Town or Loc MD Somerset Princess			11	0d. Inside City Limits 1 ☐ Yes Z No
	or 28e-	Funeral Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	itry?
	s 23e	ral	11974 Edgehill Terrace	21853	prifu Van or No	USA 14. Race - Americ	an Indian
036	ours after de	Ď	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F Yes 2X No Specify:	Rican, etc.)	Black, White,	
JA; Jek Maryland 21215-0036	hin 72 ho on "netur Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ent's Usual Occupation kind of work done during most of workir O NOT use retired)	ng 1	6b. Kind of Business/Inc	dustry
1 K	ted with lygiene her the		12 0	domestic 18. Mother's Name	/Eint Middle M	private re	esidences
Si C	ld be fil ental F ked of ic ever	To Be	17. Father's Name (First, Middle, Last) Jessie Jennings		et Mandha		
A V	d 2 shou th and M ?7 Is mar treumat			g Address (Street and Number or Rural Fairmont Road We			Code)
MARHa L. DRivek - Baltimore Maryland 21	permit. Pages 1 and 2 should be lited within 72 hours after death with the Maryland Department of Heatly and Mental Hygiene. Important: If time X7 Is marked other then "neturel", or Items 23e or 28e-1 show eny injury or other treumatic event. If a Marical Examinal must be notified at once.		20a Method of Disposition 20b. Place of Dispos			Oc. Location - City or To	wn, State
HR.	permit. Departr Importe eny injk		21. Signature of Euneral Service Licenses Ronald Salvace Director St	Name and Address of Facility ate Anatomy Board Itimore, ND 2120	655 W.	Baltimore S	treet
£	Physician /Medical		Part. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. #################################		r respiratory arre	st,	Approximate Interval Between Onset and Death
	Examiner		Due to (or as a consequence of):				
•	uted s ansit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease on Hijbry that initiated events				
8760	cate be executed by sician and the burial-transit	ledicai Examin	that initiated events resulting in death) Last Due to (or as a consequence of):				
Division of Vital Becords P.O. Box 68	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours atter death. To the Funerel Director: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delive Month	nry Day Year
r G	w requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the uni	derlying cause given in Part I.		acco use contribute to th	e cause of death? ably 4 (4 (4) (1) (1)
l Reco	sicien: The law re certilicate has bee lirector, page 2 sho	Completed			24a. Was an autopsy perform	prior to con ed? death?	osy findings available inpletion of cause of
Vita	sicien: certific irector.	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death		nce 6 Other (Specify	
ion of	or Attending Physicien: atter death. Director: After this certific in by the funeral director.	ation; To	1 ☐ Yes 2 ☐ No	3 DOA 42 Nursing Horr	ne 5 Hesider 28d. Describe how		7
Divis	el or Atte s atter des l Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office 2	28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely tilled	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invalidation on the basis of examination and/or invalidation.				
	To the To the comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, L	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, F	041094 Print)		2/13/04	. 871,
_			Vel v97542 1415 S. D	141510N 5.	Stres B	cay ND 2	1004
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	K)			

			1 - For State Registrar	State of Marylar	nd / Departme <i>Certifica</i>	nt of Health and te of Death	Mental Hygien	°2004	05542
	Physic		1. Decedent's Name (First, Middle, Las	(A) D()	GETT		2. Date of Death	ay Year	3. Time of Death
	/Medi Examir Funeral Director		4a. Facility Name (If not institution, give 5. Social Security Number 6. S	g-t-thew	SST	r Town, or Location of Deal	8. Date of Birth	9. Birthple	ce (State or Foreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. 6	ty-Town or Location	IMURE		100	d. Inside City Limits
	ath with the 23a or 28s	Funeral Director	10e. Street and Number	n thews	57	2/2	18	itizen of What Countr	Y)
900	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ta Mazical Exe unerrant ke rolified at	by	11. Marital Status 1 Never Married 22 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	I.S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer 21 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Black, White, et Specify:	
21215-0036		Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of wo	16b. 1	Kind of Business/Indu	stry
Maryland	should be filed ind Mental Hygi is marked othar umatic event, II	To Be (17. Father's Name (First, Middle, Last)	Pho	405-14-15-	11051	ne (First, Middle, Maide LG FRE	eler.	
	is 1 and 2 should by Health and Men item 27 is marke other traumatic	1	Ruce 10	ggett, Son	14174	(Street and Number or Ru	PA B	auso. n	2.
Baltimore,	permit. Pages Department of I Important: If it any injury or o once.		1 Burial 2 Cremation 3 Chemical Company Compan	Be	Place of Disposition (Nacemetery, crematory or Dockly - D) 22. Name a	nd Address of Facility	28/D4 S	ocation - City or Town	A Rolling
	20129		23a. Part1. Enter the disease, or compshock, or heart failure. List only	towers that caused the deat	h. Do not enter the mo	de of dying, such as cardial	or respiratory arrest,	s am.	pproximate interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	J Curva	indun			inset and Death
,8760,	cate be executed physician and the burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) d.					
P.O. Box 68	death certifi e attending id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 10 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 Ectopic p			23d. Date of delivery Month Da	ay Year
Ś	w requires that the been signed by th should be detache	ρ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the	
E .	The law ate has b page 2 si	Completed					24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	death?	y findings available letion of cause of ☐ No
f Viit	ys o □	To Be	25. Was case referred to medical examiner? 1 □ Yes 25 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 D	Other	th (Check only one) ome 5 Residence	6 ∏Other (Specify)	_
ion o	Attending Ph or death. ector: After th by the funeral	ertification; T	27. Manner of Death 1. Squatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju		
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certific	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify	v) 		28f. Location (Street ar City or Town, State	9)	
	n 24 hous n 24 hou he Fune pletely fil	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exem	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death occurred tion and/or investigation	at the time, date and place n, in my opinion, death occur	and due to the cause(s red at the time, date and) and manner as state d place, and due to the	e cause(s)
)	withi Tot	2	29b. Signature and title of certifier	Romo		0044 19 4	29d. Da	te signed (Month, Day	y, Year)
	(h)		30. Name and address of person who o	ompleted cause of death (Item	1 23a) (Type, Print)	NAVE BA	ettonuer M	0 21224	f
	Sta Registr	2	31. Date filed Month Day, Year)	32. Registrar's Signa	ture & Sou	rds/			

			For State Registrar	State of Mar	ylanc	l / Depa <i>Cer</i>	rtment <i>tificate</i>	of H	ealth a Death	and M		giene Reg. No		004	05543
	Physici	an	1. Decedent's Name (First, Middle, Last) RICHARD J.	DUCKE	TT 5	SR.					2. Date of De Februa	ath Da		Yeer	3. Time of Death \$: 20 A, M,
	/Medic Examin		4e. Facility Name (If not institution, give s	street and number)	PI		4b. City, To	own, or	Location of	of Death	_		County		RUNDEL
	Funeral Director		5. Social Security Number 215-66-4396 10	7. Age (st birthday) Yrs.	ff Under 1 Months	Year	If Under Hours	24 Hrs.	8. Date of Bir (Month, Da Feb. 24	th y, Year) + 19	63		ace (State or Foreign ry) Land
	pu »		Usuel Residence of Decedent 10a. State 10b. County			Town or Loc	cation								Od. Inside City Limits
O	death with the Maryland ims 23s or 28s-1 show if Intel Le Indilled at	ctor	Md. Anne Arun	idel Co.	M:	illers	ville								1 ☐ Yes 2 No
NAR	th with the 23a or 28	i Director	10e. Street and Number 521 Old Mill Roa	ď			10f. Zip C	ode 2110	8			_	U.S.	What Count	ry?
1)	rs after death with the Maryla ", or Itams 23a or 28a-f shov	Funeral		12. Was Decedent Eve Armed Forces? 1 Yes 2 NNo	er in U.S		Vas Deceder Yes, specify		spanic Ori , Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	>-	Biac	e - America ck, White, e	etc.
21215-0036	72 hours "natural",	ed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	16a. Deced	ent's Usual	Occupa	tion			16b. K		whi	
215		Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		(Give life. [kind of work OO NOT use	done di retired)	uring mos		ng				
	I Hygier other ti	Be Col	12 17. Father's Name (First, Middle, Last)	0		Sneet	Meta.				(First, Middle			Local	100
e++	should be and Mental a marked of umatic eve	To B	Robert L. Duckett							-	Lycett				21100
Mar	and 2 sh eaith and n 27 is m		19a. Informant's Name/Relationship (Ty) Robert L. Duckett		her										Code) 21108 1e, Md.
$\sum_{\mathcal{U} \subset \mathcal{C}}$ Baltimore,	ges 1 If iter or oth		20a. Method of Disposition 1 ◯XBurial 2 □ Cremation 3 □R 1 □ Donation 5 □ Other (Specify)	emoval from State	Cei	nce of Dispos metery, crem dar Hi	natory or other	er place			9/04			City or Tov	
Balti	permit. Par Departmen Important: any injury once.		21. Signature of Fundal Service License	Kevin E.	Eck	er 22	Name and MC	Address CCu I 204	f Facility Moun	olyn: tain	iak Fun Road.	era Pasa	l Horadena	ne P.	A. . 21122
			23a. Parti. Enter the disease, or complishock, or heart failure. List only or	cations that caused the cause on each fine.	e death.	Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to for as a c	onseque		15	me	加拉	313				4	7-425.
	Examiner	P.	Sequentially list conditions,	Due to (or as a c	Juseyu	ance off.									
R	ecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
38	ite be executed lysician and ne burial-transit	ical Ex	resulting in deality Last	Due to (or as a c	onseque	ence of):									
689			IF FEMALE:												
P.O. Box 66	Attanding Physician: The law requires that the death certifics or death. In death. In death. In this certificate has been signed by the attending pt by the funeral director, page 2 should be detached for use as the funeral director.	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 { 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetaf	death 3 🗆	Ectopic preg Other (spec						23d. Dat Moi	e of deliver	y Day Year
ds, P.	uires that the signed by Id be detact	by	Part II. Other significant conditions con	stributing to death but r	not resul	ting in the un	iderlying cau	ise give	n in Part I.		3.				e cause of death?
ecor	e law requii has been s je 2 should	Completed									24a. Was		24b. V	Vere autop	sy findings available ipletion of cause of
Tal B	ysician: The is certificate hadirector, page	е Соп	25. Was case referred to medical						OC Plane	of Dooth	1 ☐ Yes	2X No	1	leath?	No
Ž	Physicia this cert al directe	To B	examiner?	lospital: 1 X Impatient		R/Outpatient		Acres -	4 □ Nu		(Check only only only one 5 ☐ Resident		6 □Othe	er (Specify)	
o uo	iding Ph th. : After th funeral	tlon:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. D te of Injury (Month, Day Y	ear)	28b. Time of Injury	28d	injury Work 1 🗆 Y	at ? es 2 □ i	į.	28d. Describe I	how in j u	ry occurr	ed	
Division of Vital Records,	P Pie	Certification:	3 Suicide 6 Could not be determined	28e. Pface of Injury building, etc. (- At hon (Specify)	ne, farm, stre	eet, factory, o	office		2	28f. Location (S City or Tox	Street ar wn, State	nd Numbe e)	er or Rural	Route Number,
	To the Hospital within 24 hours and the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of refer: On the basis of example and manner states	caminatio	ledge, death on and/or inv	occurred at estigation, in	the time	e, date an nion, dea	d place, a	and due to the ad at the time,	cause(s date and) and ma d place, a	nner as sta and due to	ited. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. 1	License	number			29d. Da	te signed	(Month, D	lay, Year)
	5		30 Name and adverses of person who co	mpleted_cause of deat	th (Item:	23a) (Type: F	Print)	14	397	7		Hessy	inan	1 17	2004
_			anoka Orezing	1.301 45	3/2	1 Der	vi, C	ilar	Su	mil	·m	3.	2/1	1 / bl.	
	Sta Registr		31. Date filed (Month, Day, Year) FFR 2. 3. 200	32. Registrar's	Sighati -a/	ire Kaj	1-		47					•	

Amend Item 23a petate of Manyland Department of Health and Mental Hygiene 2004 05544 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUAR Year **Physician** GAINES DICKERSON 23:42 M 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BACTIMORE JOHNS HOPKINS BAYNIEW CARE CENTER BALTIMORE COT If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Hours 1⊠M 2□F Months Director 216-10-4043 Virginia Sept. 20,1912 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-f show Examiner must be notified at 1 ☐ Yes 2 No Dundalk Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With ö 21222 United States 1752 Stokesley Road Itеms 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) al Hygiene. 12 Years Ship Yard Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental is marked 2 Noah W. Dickerson Lucy Ann Watson 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i 1752 Stokesley Road Dundalk, Maryland 21222 Mrs. Laulette R. Dickerson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ₹ ... ₽ Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 520 Other (SpecifyEntombment Oak Lawn Cemetery 2/3/2004 Baltimore, Maryland 21. Signature of Funeral Service Deensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. ▶ 7922 Wise Ave. Dundalk, Maryland 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia **Physician** MONTH /Medical Due to (or as a consequence of): Parkinson's Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed RKINSONIS burial-tran and Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) Ö detached 9 Unknown þ ۵ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other. 4 Viursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury Natural 5 Pending within 24 hours are: ...
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D DOO 602 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHMAZIZ 5505 HOPKINS BAYVIEW CIRCLE BALTIMO HEIDI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 3 2004 Registrar

			1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H tificate of L	ealth and Death		iene 20	04 0	1554
	Physici /Medi		1. Decedent's Name (First, Middle, Last) YEYZH		D	YNIN		2. Date of Deal Month FEBRUAR	Y 18, 20	9:004 9:0	ne of Death
	Examir	ner	4a. Facility Name (If not institution, give st JEWISH CONVALESCE 5. Social Security Number 6. Sex		ast hirthday)	4b. City, Town, or BALTIM			· ·	f Death _TIMORE 9. Birthplace (S	tata or Foreign
ŀ	Funeral Director		214-49-1863 Usual Residence of Decedent	M 2□F 8	8 Yrs.	Months Days	Hours Min.	MAR. 20,	1915	Country) BEI	ARUS
	the Marytar 28a-f show collised at	Director	MD BALTI 10e. Street and Number		OWI	NGS MILLS		1	Og. Citizen of Wh	1 🗆	de City Limits
336	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or flems 23a or 28a-f show with the Medical Exerciting the English at	by Funeral Dir	2 STONEMARK COURT	#7 2. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:	ł	Vas Decedent of Hi Yes, specify Cubar	21117 spanic Origin? (S n, Mexican, Puer Specify:		14. Race	i .	
21215-003	be filed within 72 hours tal Hygiene. d other than "natural", event, the Medical Ext	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-40(5+)	(Give life. L	lent's Usual Occupa kind of work done d DO NOT use retired, _ I SHER	luring most of wo	rking	16b. Kind of Bus	ME)IA
Maryland 21	Mental Mental arked o	To Be	17. Father's Name (First, Middle, Last) YANKEL		DYN		TSIVA			(UNKNOW	IN)
e, Mar	s 1 and 2 sho if Health and Item 27 Is m other traum		19a. Informant's Name/Relationship (<i>Typ</i> TSIVA ZERNOVA / D 20a. Method of Disposition	AUGHTER	2 S	g Address (Street a FONEMARK sition (Name of		- OWING	S MILLS,	MD 211	
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		1 N Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State CHIZ	ometery, cren ZUK AMI	JNO ARLIN	GTON 2/2	20/2004		MORE, M	1D
Ra	Depar Depar Impor any in		21. Signature Funeral Service Licenset	itter		Name and Addres REIS	TERSTOWN		PIKESVIL		21208
8/60,	The law requires that the death certificate be executed was been signed by the attending physician and upon the has been signed by the attending physician and upon the burial-transit upon as the burial-transit.	dical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of the consequence of t	e (dence of): hence of):	pper (Egper- mer	si b Leus	loedir ion mea.	rg.	Interva	I Between and Death MM u.
O. Box 6	the death certific y the attending p ched for use as I	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date Month		Year
rds, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions cont	ibuting to death but not resu	lting in the ur	derlying cause give	n in Part I.	23e. Did tob	pacco use contrib	ute to the cause	
vital Records,		Completed						24a. Was ar autops perform 1 Yes 2	aleal? dea	ere autopsy find or to completion ath? Yes 2 \(\text{No}	
ō	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification: To Be	25. Was case referred to medical examiner? Yes 22 No Ho 27. Manner of Death Natural 5 Pending investigation 3 Suicide 6 Could not be determined		ER/Outpatient 28b. Time of Injury	28c. Injury Work M 1 \(\text{Y}	r: 4 Nursing H	ath (Check only one ome 5 Reside 28d. Describe ho 28f. Location (Str City or Town	nce 6 □Other w injury occurred		Number,
<u>ה</u>	lospital or hours aft uneral Di	edical Cer	29a. Certifier W. Certifying Physi	cian: To the best of my known:	vledge, death	occurred at the time	e, date and place	and due to the ca	use/s) and mann	er as stated.	ueo(e)
	To the I within 2. To the F complete	Medi	29b. Signature and title of certifier	and manner stated.		DDC	number) 5 4 7 4	6	02/19	Month, Day, Ye	
			30. Name and address of person who com A POKOV, WI.D. 68	11 Reilyach	23a) (Type, F	\$ # 206.	Baltin	re, no	21215		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Register's Signat	J. J.	Sperie					

State of Maryland / Department of Health and Mental Hygiene 2004 05546 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Z s 4 Day **Physician** 12:15 PM **EVANS** CHARLES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE n/a If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 1 M 2 □ F 78 Director 212-20-5534 Dec.12 1925 Maryland Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23s or 28s-f show the Medical Examinar must be nutified at 1 Tyyes 2 □ No Baltimore n/a Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with I ment of Health and Mental Hygiene.
ant: If term 27 le marked other than "naturat", or items 23a or ; any or other transatic event. It is Medical Experience must be not you or other traumatic event. It is Medical Experience must be not as the most term and the property or other traumatic event. 1504 Belt Street 21230 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter Goetz Meats 12 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Evans Frances Lillian Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1504 Belt Street, Baltimore, Md. 21230 Shirley 1. Evans (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any in|ury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran Cem. 02/23/04 Crownsville. Md. 21. Signature of Funeral Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230 1001 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final disease or condition **Physician** /Medical resulting in death) days **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): burial-t physician Physiclan/Medical the t use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 mornins? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy for Month 5 Other (specify) signed by the a 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No. Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate ha autopsy perform 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 Yes 2 No Certification; To 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funaral Diractor: . completely filled in by the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier agrici 30. Name and address of person who completed cause of death (Item 23a) (Type, Pfint) 00 non SISMUND 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2604 05547 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Charles February Eckert 19 2004 12:40 AM /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Pasadena If Under 1 Year If Under 24 Hrs. 241 Carroll Road Anne Arundel 8. Date of Birth (Month, Day, Y April 21 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Year Months Days Min. 1 X M 2 ☐ F Yrs 59 Director 215-42-0567 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10a State 10b County 1 ☐ Yes 2 🛛 No Pasadena Anne Arundel Marvland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 USA 241 Carroll Road Funerai death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Elementary/Secondary (0-12) College (1-4or 5+) Tool & Die Maker Maintenance of Health and Mental Hygie fitam 27 is marked other ir other traumatic event, IL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Viola Elizabeth Allen Eckert George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 241 Carroll Road, Pasadena, MD 21122 Trudy L. Eckert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland * 4 □ Donation 5 Other (Specify) Metro Crematory Inc. 21. Signature of Funeral Service Libensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, nding physician use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1 Yes □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only Other: 4 Nursing Home Hospital: 2010 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 2 1 Inpatient 1 🗌 Yes this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier (30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 06 31. Date filed (Month, Day, Year) 32. Registrar's Signajure

DHMH 17 Rev 1/2001

State Registrar

FFB 2 3 2004

Frederick Fekays Jr.

State of Maryland / Department of Health and Mental Hydiene

			Registrar F	23a,Paı	t II,	² der	liffcate of	6828,3/	T/OTE BRE	g. No.	4 05548
	Physici	an	Decedent's Name (First, Middle, Last)			-			2. Date of Deati	Day Year	3. Time of Death
	/Media	al	FREDERICK ALL 4a. Facility Name (If not institution, give stre		FEKAYS	JR.	4h City Town o	r Location of Death	Februar	y 1/ 2004 4c. County of De	
	Examir	er	1557 Stoney Beach				Pasaden			Anne Aru	
	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age	o (In yrs. last bir 46	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 20		orthplace (State or Foreign Country) ryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Lo	cation				10d. Inside City Limits
	Maryl 4 sho	ror	Md. Anne Arun	del Co.	Pas						1 ☐ Yes 2 📉 No
	r 28a	irec	10e. Street and Number				10f. Zip Code		10	g. Citizen of What (Country?
	th wit	ai D	1557 Stoney Beach	Way			212	26		U.S.A.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itama 23e or 28e-1 show any injury or other traumatic event, its Medical Everthar must be notified at ADGE.	Completed by Funeral Director	11. Marital Status 12. 1 ☼ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		1	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
Q 2	72 ho	ted	15. Decedent's Educat (Specify only highest grade of	ion	16a.	Deced	ent's Usual Occup	ation during most of work	ına 1	6b. Kind of Busines	s/Industry
Baltimore, Maryland 21215-0036	filed within Hygiene. other than "ant, Lie Mer	Comple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. D	S.A.	1)		Federal G	overnment
ylanc	nould be fi Mental It harked ot hatic ever	To Be	17. Father's Name (First, Middle, Last) Frederick Aller		ekays		r.		adeline	Mur	
ğ Z	d2st thanc 7 Is n traun		19a. Informant's Name/Relationship (Type, Denise M. Patane	(Sist						City or Town, State,	Zip Code)
<u>6</u>	s 1 an f Heal item 2 other		20a. Method of Disposition	(3131	20b. Place of	Dispos	sition (Name of natory or other place			Md. 21401 Oc. Location - City of	r Town, State
Ë	Page nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)	loval from State					/21/04	Glen Burn	ie, Md.
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee	moog	2.2	22.	Name and Addre McCu. 237	ss of Facility 11-Polyni E. Patans	ak Funer	al Home P Baltimore	.A. . Md. 21225
			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of			not ente	or the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition					yperten: e			Onset and Death
t	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):	DISCUS				
身.		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a	a consequence	of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events c.								
8	tificate be executed og physician and as the burial-transit	Еха	resulting in death) Last	Due to (or as a	consequence	of):					
687603	ate be hysici the bu	edicai	d								
P.O. Box 6	The law requires that the death centificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 🗍 Fetal death		Ectopic pregnancy Other (specify)	,		23d. Date of di Month	elivery Day Year
	that the	/ Ph	Part II. Other significant conditions contrib	outing to death bu	t not resulting in	the un	derlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
rds	quires tha n signed uld be det	q pa	Hepatosplenomega	ıly					1 ☐ Ye	s 2 □ No 3 □ F	robably 4 Unknown
Division of Vital Records,	10	Completed							24a. Was an autopsy perform	prior to	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	pital:			a DOA Oth	26. Place of Deat	(Check only one)	
ō	Phys this ral di	: To	IX) tes 2□ NO	1 ∐ Inpatier 28a. Date of Injur	y 28b. T	tpatient ime of	28c. Injur	v at	me 5 Resider 28d. Describe how	nce 6 (20) ther (Sp. v injury occurred	ecify) at scene
<u>o</u>	Attanding I r death. actor: After by the funer	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) li	njury	Wor	k? Yes 2 □ No			
Divis	i Pite	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, fa . (Specify)	rm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	tural Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Physici 2X Medical Examiner	an: To the best of : On the basis of and manner sta	examination and	, death d/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occurr	and due to the cared at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To t withi To tl	ž	29b. Signature and title of certifier	1			29c. Licens	e number	t t	d. Date signed (Mor	*
•			* taleilla		•		OCME			February	18 ZUU4
_			30. Name and address of person who comp	leted cause of de	eath (Item 23a) (Туре, ғ	111 P	enn Stree	t, Balti	more, Mar	yland 21201

Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05549 1- State
RegistrarAmend Item//*perFHG9292/23/04 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY T FINKELSTEIN 19, 2004 11:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 1 ☐ M 2 🕠 F Director 173-26-8628 90 **POLAND** Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or iteme 23a or 28a-f ehow Exertiner must be notified at Director BALTIMORE 1 ☐ Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4204 OLD MILFORD MILL ROAD 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No þ Specify. WHITE 3 Widowed 4 Divorced "naturel", Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 ie marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** BLANK'S FABRIC STORE 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) **ENOCH** LEIKACH 2 SHANA ARMARNICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 ie meny injury or other traum once. HARRIET SCHULMAN / NIECE 2204 SHEFFLIN COURT - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from * 4 ☐ Donation 5 ☐ Other (Specify) > BETH TFILOH CEMETERY 2/20/2004 WOODLAWN, MD uneral ervice Li 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part I. Enter the disease, or complication that caused the shock, or heart failure. List only one hause on each line. complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Me au /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): to the Hospitel or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2⊠ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ZNo 3 DOA funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending Injury death 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month. Day. Year) 37573 Februar 19,2004 30. Name and address of person who concleted cluse of death (Item 23a) (Type, Print) Reistersteur MP 2004 Na. 31. Date filed (Month, State Registrar

		1	State of Maryland / Departm State of Maryland / Departm State of Maryland / Departm Certific	ent of Health and M cate of Death	ental Hygiene Reg. No		05550
			Decedent's Name (First, Middle, Last)		2. Date of Death Month Da		3. Time of Death
	Physicia /Medic		Julia HELENA Cuy		Jm 31	2004	0551 M
>	Examin	ar 1	4a. Fecility Name (If not institution, give street and number) 4b. (City, Town, or Location of Death		c. County of Death	
			UNION MEMORIAL HOSPITUL	Baltite	8. Date of Birth	9 Birtholes	e (State or Foreign
2	Funeral		5. Social Security Number 6. Sex 7. Age (in yrs. last birthoay) Mon		_(Month, Day, Year	SIP MAN	"
	Director	4	J/y 4/ p 9 59 IIIM 23 /6 Yrs. Usual Residence of Decedent		04 6 7	17.80	4 long
	land ow)-	10a. State 10b. County 10c. City, Town or Location			10d.	Inside City Limits
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	r 288	Director	Tog. Street and redition	f. Zip Code	1	itizen of What Country	17
	th wit		701 RICHLIOD AUG	21212		US /A	Indian
	r dea	Funerai		Decedent of Hispanic Origin? (Spe , specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc	
36	hours after death with the Maryland tural, or Items 23a or 28a-f show al Examiner must be notified at	by Fu	1 Never Married 2 Marned 1 Yes 2 No If Yes, Give 1 Yes ar or Dates:	es 2 No Specify:		Specify: Blac	la
21215-003	hour tural	be	15 Decedent's	Usual Occupation		Kind of Business/Indus	stry
T.	filed within 72 Hygiene. Hyser then "nel ent, the Medic	Completed	(Specify only highest grade completed) (Give kind of life. DO No. 10 (Give kind of life. DO No.	of work done during most of work OT use retired)	() 1	, /	
2	filed with Hygiene other tha	EO	36 grade	nestic		wake formi	4
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Maryland	C1 (0 = 0			1-		M 2121	
	l and lealth om 27 ther tr		20b. Place of Disposition			Location - City or Town	
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Baltimore,	it. Partmer				114 Th da		Front Hance
Ba	permit. Pages 1 an Department of Heal Important: If Item 2 sny injury or other 2008.		524	a Reistentow.	~ Rel Ba	1/20018	12/2/2/5
	200		as a sufficient of complications that caused the death. Do not enter the	mode of dving, such as cardiac		Î Î	Approximate nterval Between
	Dhysician		shock, or hear failure. List only one cause on each line. Terminal Aspi	ration			Onset and Death One year
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	- lateral	= 10,000		
	Examiner		Sequentially list conditions b. am yo trophic	- la Terul	5 6/2003)) 0	ine yeur
7	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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687	phys s the	edical	d				
ox 6	eath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant	opic pregnancy		23d. Date of delivery	
Вох	d for u	ciai	TOUR BILL E COLOR COURT OF THE COLOR COURT OF THE COLOR COLO	ner (specify)		Month D	Day Year
0	that the de	hys	9 Unknown		OO Didahan	o use contribute to the	course of death?
S,	res tha igned be del		Part II. Dther significent conditions contributing to death but not resulting in the underly Cormany are tery dissert				bly 4 Dunknown
ord	w require been sig	Completed by	Cornary andery disease		-		
ec C	law r las be	pie	17 y perfension,		24a. Was an autopsy performed	prior to com death?	sy findings available spletion of cause of
E B	The cate h	So	asthma.		1 ☐ Yes 2 🖎	No 1 ☐ Yes 2	2 No
of Vital Records,	Physician: The law this certificate has trail director, page 2 s	Be	25. Was case referred to medical examiner? Hospital: Hospital:	10:	th (Check only one)	6 ☐Other (Specify))
of	this ald	. To	1 Yes 24 No 1 Inpatient 218 Produpatient 3	BDOA 4 Nursing H 28c. Injury at Work?	28d. Describe how in		<u></u>
	ding h. After fune	tion	1 Statural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 Yes 2 No			
Division	Atten deal actor: by the	fica	3 Suicide 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, St	t and Number or Rural tate)	Route Number,
Ö	s after	Certification:	4 Homicide Building, std. (Specify)				
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ical (29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occ Check only 2 Medical Examiner: On the basis of examination and/or investigation.	curred at the time, date and place igation, in my opinion, death occu	, and due to the cause irred at the time, date	e(s) and manner as stated and place, and due to	ated. the cause(s)
	the	Medical	one) and manner stated. 29b. Signature and the of certifier	29c. License number	29d.	Date signed (Month, D	Day, Year)
	T W		1//	D580	94	2/2/2	2004
	(3)		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	no Ini	n menu	1 429.	01/4/
		tate	EFR 2 3 7100 630 630 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	2			
	Regis	trar	EFM WA COOL WOOD				

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** MICHAEL FERLUARY 20. 2604 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PANAA118 TO-CON Nonthics HESPITAL CONTON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F 52 Director 195 40 3895 APRIL 21,1951 NEW YORK Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits worle Items 23a or 28e-f ehov 1 Yes 2 No Directo MD. BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3301 FIRELIGHT LANE APT. K 21207 U.S. OF A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, BLACKite, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UNEMPLOYED 12TH 1½ YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EARL GOLDEN ELIZABETH UROHART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n any injury or other traun JANNET D. GOLDEN (WIFE) 3301 FIRELIGHT LANE BALTO., MD. 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State MT. ZION CEMETERY 2/25/04 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) LANSDOWNE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LEWIS T GWYNN LEWIS T. GWYNN FUNERAL HOME 21215-6393 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTO , MD ximate Immediate Cause (Final **Physician** SEPSES disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, it any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed the burial-transit and Due to (or as a consequence of) attending physician Physiclan/Medlcal use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ENDSTACE REMAL DIRECTLE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No autopsy performed? NEGATIVE 68 ACIULACE Division of Vital 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Dispatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending 1 Tes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. investigation 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide pellil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ferminy 26, 200d 30. Name and address of person who complet of cause of death (Item 23a) (Type, Print) MENTHALIST HESPITAL CONTOR ENHANCE B- CONANAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ooks FFB 2 3 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 2 10 L

		•	1 - For State Registrar	State of Maryla		artment of F		nd Menta	Il Hygier Reg. I		05552
	Dhysioi		1. Decedent's Name (First, Middle, L	ast)			-	Mo	e of Death	Day Yeer /	3. Time of Death
П	Physici: /Medic		Mary	F. Gaith	er	T # 65 T	-1		ruary	20, 4004	1:30PM
	Examin	er	4a. Facility Name (If not institution)	NEK HOT 2	29	4b. City, Town, o	MORE	rDeath		4c. County of Deeth	
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs	, last birthday	If Under 1 Year	If Under 2	4 Hrs. 8. Dat	e of Birth	9. Birthp	lace (State or Foreign
· 4	Director		217-30-4553	1 M 201 7	Yrs.	Months Days	Hours	Min. MA	7.20,1	933 N.C	arolina
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation				1	Od. Inside City Limits
	Mary I eho	ţō	mo NA	9 6	altin	nore					1 Pres 2 □ No
	be filed within 72 hours after death with the Maryland at all tyglene. Ide Hyglene and Internally, or items 23a or 28a-f show other then "naturally or items 23a or 28a-f show event, the Medical Examinar must be invitted a	Funeral Director	10e. Street and Number	10.4 no	+ 27	10f. Zip Code	2007		10g.	Citizen of What Cour	itry?
	ath wi	rai	3501 HOWARD	Park 17p	1,901	dia	07	:-2 (C:t- V-	(14. Race - Americ	ean Indian
	ter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☐ No	0.5.	Was Decedent of H If Yes, specify Cub	,	Puerto Rican,	etc.)	Black, White,	
98	ral', or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:			Specify: 19/1	ucr
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12	within ene. then	duic	Elementary/Secondary (0-12)	College (1-4or 5+)	Don	DO NOT use retire	ia)		/	40mes	
2	filed Hygi other	Be C	17 Father's Name (First, Middle, La.	st)	10		18. Mother	rs Name (First,	Middle, Maid	den Sumame)	
<u>lar</u>	should be filed within nd Mental Hygiene. I marked other then umatic event, Ine M	ToB	Presel Mabr	/			KUT	h ba	Ker		
Maryland	2 9 5 9		19a Informant's Name/Relationship	Type, Print) - SICTER	19b. Mail	ing Address (Street	and Number	r or Rural Route	Number, Cit	y or Town, State, Zip	Code)
	1 and Health Health Health		20a. Method of Disposition		Place of Disp	osition (Name of	1411101	Date	200	Location - City or To	
ltimore,	Pages nent of I int: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 9 ☐ Other (Spec		DUTU.	ematory or other pla	PK. 0	7-25-0	4 /1	butus, 1	MA
a	permit. Pag Department Important: I eny injury o		21. Signature of Buneral Service Lic		1	2. Name and Addre	ess of Facility	-11/20	105.1	11:11 00	21229
<u> </u>	88188		Xmy (1/1/	mel	[6]	pary P. 1410	urch 1	MH d't	V Hea.	nilton Pasi	S BALTO, MD
4			23a. Part / Enerthe disease, or co shock or bear failure. List on	mplications that caused the de- ly one cause on each line.	ath. Do not er						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	Table	acute	myo	Carallet	11/7	irchan	
	Examiner				1877	SUD	•				
1	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):						
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse	equence of):						
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687	g phy: as the			U							
Вох	ith cer tendin ir use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	tel death 3	□Ectopic pregnanc	у			23d. Date of delive	Day Year
о. П	the at	ysici	1 Ves 2 No	4☐ Pregnant at time of 9☐ Unknown	death 5	Other (specify) _					
<u> </u>	The law requires that the death certifics ate has been signed by the attending propage 2 should be detached for use as it.	by Physician/Med	Part II. Other significent conditions	contributing to death but not re	sulting in the	underlying cause gr	ven in Part I.	23	Be. Did tobacc	co use contribute to the	ne cause of death?
rds,	w requires been sign should be		1 tepati	45 C	,	/			1 🗆 Yes	2 □ No 3 Prot	ably 4 Unknown
Vital Record	e law requ has been ge 2 should	Completed	Deginerati	ve av thrit	-15	both he	jis	24	a. Was an autopsy	prior to co	psy findings available mpletion of cause of
<u> </u>	: The cate h	Con	Mem	where atm	al des	, tracti	ons	10	performed Yes 2/2	? death? No 1 Yes	2 No
Vita	Physician: r this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:	758/Out	ot ot	her	of Death (Chec		6 DOther (Const	
	Physer this eral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	of 28c. Inju				e 6 □Other (Specificial occurred)	y)
ion	Attending r death. ector: After by the funer	atio	1. Natural 5 Pending 2 Accident investigat	ion	Injury		Yes 2 N	No			
Division of	or Atte	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		home, farm, s cify)	street, factory, office			cation (Street by or Town, St	t and Number or Rura tate)	i Route Number,
	pital ours a nerel Dilled		29a. Certifier 12 Certifying	Physician: To the best of my ki	nowledge, dea	ath occurred at the ti	ime, date and	d place, and due	e to the cause	e(s) and manner as s	taled.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Ex	aminer: On the basis of examinand manner stated.	nation and/or i	investigation, in my	opinion, deat	th occurred at th	ne time, date	and place, and due to	the cause(s)
	To the troop comp	M	29b. Signature and title of certifier		4	29c. Licen	se number	67	29d.	Date signed (Month,	Day, Year)
	5		7 allum	4 Jane	. 11		1001	8350		62/23/	164
	Ö		30. Name and address of person when the same and address of person	no completed cause of death (It	9m 23a) (Type	ard J	Sute 1	20 2	1216		
The same	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig		/			/ 0		
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	State of Maryland /	Department of Health and M	Mental Hygiene	00000
and	Item#2perDVRG8282/24/04 EW	Department of Health and Macertificate of Death	Pag No 2004	05553

Sec. F	Physician
	/Medical

Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be nutified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

		Last)						2. Date of D Month	eath Fel		Year	3. Time of D	
	William J. Hoo	ok						Febru		18,	200	3 15:59	P
- \$	4a. Facility Name (If not institution, g	give street and nu	imber)				tion of Death		40	c. Count	y of Death	1	
	12 Conkling Str					timor							
	5. Social Security Number 6 215-64-8810	.Sex 1⊠M 2□F	7. Age (In) 49	vrs. last birtho Yr:	Months [Year If Or Days Hou	nder 24 Hrs. urs Min.	8. Date of B (Month, C Sept 8	irth lay, Year	354	9. Birth Cou West	place (State or Intry) Uirgin	Fore
	Usual Residence of Decedent												
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}	10e, Street and Number	and Number					10f. Zip Code					untry?	
	12 S. Conkling	g Street				L224			109.01	US		and y :	
	11. Marital Status	12. Was Dec Armed F	edent Ever i	n U.S.	13. Was Deceder II Yes, specify	t of Hispanie	c Origin? (Sp	ecify Yes or N	0-		ce - Amer	ican Indian,	
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	15. Decedent's (Specify only highest of	Education grade completed)		16a. De	ecedent's Usual (Give kind of work of fe. DO NOT use	Occupation done during	most of work	cing .	16b. k	Kind of E	Business/li	ndustry	
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-	17 February 11 //**	U (and)			securit	-		a /Fire * * * * * * * * * * * * * * * * * * *	_		fron	ts	
	17. Father's Name (First, Middle, La Gentry Hook	ist)				18. N		e (First, Middl		n Sumai	me)		
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	21. Signal of Financial Scholar		or	22. Name and A State An Baltimor	latomy	Board	,655 W	Bal	ltim	ore 9	Street		
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	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to b. Due to c. Due to d	(or as a con (or as a con (or as a con atcome of pre- birth 2 French at time shown	sequence of): sequence of): grancy retal death of death	3 □Ectopic preg 5 □ Other (speci	nancy		sease			ate of delive	Onset and De	eath
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	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Xes 2 No 27. Manner of Death 1 Xes 2 Pending	a. Due to b. Due to c. Due to d	(or as a con (or as a con (or as a con itcome of pre- birth 2 Franch at time- lown	sequence of): sequence of): sequence of): gnancy retal death of death resulting in th	3 Ectopic pregs 5 Other (special period of the underlying cause) attent 3 DOA are of 28c.	nancy fy)se given in P	Part I. Place of Deat	23e. Did 1 24a. Wa auto perf 1 Yes	Yes 2 s an opsy ormed? 2 No one) idence	Mo use con 2 □ No 24b.	tribute to I	Onset and De Yer Day Ye the cause of dea bably 4 Jun opsy findings av ompletion of cau	aar aath? railal
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	disease or condition resulting in death) Sequentially list conditions, if day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to b. Due to c. Due to d	(or as a con (o	sequence of): sequence of): gnancy fetal death of death resulting in th 2 DER/Outpa 28b. Tim Inju at home, larm ecify)	3 Ectopic pregs 5 Other (special and special and speci	nancy fy) 26. F Cther: 4 [Injury at Work? 1 [] Yes:	Part I. Place of Deat Nursing Ho 2 \(\text{No} \) e and place, death occurr	23e. Did 1	yes 2 s an oppy ormed? 2 No one) idence how inju (Street arwn, State cause(s, date and	use con 2 No 24b. 24b. 24b. 24b. 24b. 24b. 24b. 24c. 24c. 24c. 24d.	tribute to I 3 Pro Were autreprior to cc death? 1 Yes Ther (Special or Runner of Run	onset and De very Day Ye the cause of dea bably bably opsy findings av moletion of cau 2 No fy) At SCe al Route Number	ear kno raila ese (
<u> </u>	disease or condition resulting in death) Sequentially list conditions, if day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to b. Due to c. Due to d	(or as a con (o	sequence of): se	3 Ectopic pregs 5 Other (special and special and speci	26. F Cther: 4 Injury at Work? 1 Yes the time, dat my opinion, icense numb	Place of Deat Nursing Ho 2 No e and place, death occurr	23e. Did 1	yes 2 s an oppy ormed? 2 No one) idence how inju (Street armen, State cause(s, date and 29d. Da Febi	use con 2 No 24b. 24b. 24b. 24b. 24b. 24b. 24c. 24c	tribute to 1 3 Pro Were autt prior to codeath? 1 Yes her (Special Special Spec	onset and De very Day Ye the cause of dea bably 4 fun opsy findings av ompletion of cau 2 No fy) At SCE al Route Number stated. o the cause(s) Day, Year)	ear ath? kno raile ise (

Registrar

			For State Registrar	State of Marylan	d / Depa	artment of H	ealth and M Death	ental Hygie	ene 2004	05554
el,	Dhorisi	4	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
(Physici /Medio		June V. Higgins					FEB 2	2 2004	12:15 A M
	Examir	er	4a. Facility Name (If not institution, give s				Location of Death		4c. County of Dea	
			ST. VINCENT de P. 5. Social Security Number 6. Sex			FROST		8. Date of Birth	ALLEGA	NY thplace (State or Foreign
П	Funeral Director			M 2X F 82		Months Days	Hours Min.	(Month, Day, Y	ear) C	RYLAND
	pc ,		Usual Residence of Decedent							
	within 72 hours after death with the Maryland one. than "natural", or Items 23a or 28e-f ahow is Modical Evaminatings at a redified at	7	10a. State 10b. County		/, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	the M	Director	MARYLAND ALLEGANY 10e. Street and Number	FRO	OSTBURG	10f. Zip Code		100	. Citizen of What C	
	with Mark	iOi	17503 POMPEY SMASH	ROAD, SW		2153	2	109	U.S.	buritry:
	death ms 23	by Funerai		2. Was Decedent Ever in U.	S. 13. V	Vas Decedent of Hi	spanic Origin? (Spe	cify Yes or No-	14. Race - Ami	
9	after o	Fur	X Never Married 2 Married	Armed Forces?		Yes, specify Cuba □ Yes 2 XNo	n, Mexican, Puèrto I	Rican, etc.)	Black, Whi	te, etc.
සු	ral,		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		THES ZLAINO	Specify:		Specify:	WHITE
<u>7</u>	"nati	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	lent's Usual Occupa kind of work done of OO NOT use retired	ation furing most of workir)	ng 161	b. Kind of Business	/Industry
7	withir ene. than	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)		OMEMAKER	,		OWN H	OME
2	Hygie other ent, II	Be Co	17. Father's Name (First, Middle, Last)	I	- 110	TILIZAKEK	18. Mother's Name	(First, Middle, Mai		OHL
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hyglene. item 27 is marked other than "natural", or Items 23a or 28e-f ahow other traumetic event, If a Modical Examination must be notified at	ToB	WILLIAM HIGGIN	IS			BES	SIE FATK	IN	
ary	2 shou and M is mai	Γ,	19a. Informant's Name/Relationship (Type			-	ind Number or Rura		*	· ·
	l and 2 lealth im 27 i		MARION EVERLINE / S				RIDGE LA			
altimore,	m 0		20a. Method of Disposition 1 Disposition 3 □R	1 4	lace of Dispos emetery, cren	sition (Name of natory or other place			c. Location - City or	
Ē	Pag tment tant:		`4 ☐Donation 5 ☐ Other (Specify)	VAI			ERY 2/24/	04 VAI	LE SUMMIT	, MD
Ba	permit. Page Department Important: If any injury o		21. Signature of Funeral Service License	n. Lower	V	Name and Addres	s of Facility ERAL HOME	, P.A. 60	W. MAIN	ST. MD 21532
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death e cause on each line.	. Do not ente	er the mode of dying	g, such as cardiac of	r respiratory arrest,		Approximate Interval Between Onset_and Death
8	Physician	9 1	Immediate Cause (Final disease or condition resulting in death)	Advan	ced	Deme	ntu.			- Emonth
	/Medicat Examiner		resulting in deathy	Due to (or as a consequ	ience of):					
		e	Sequentially list conditions, if any, leading to immediate gauss. Enter Underlying	. Due to (or as a consequ	ience of):					
	uted	Examiner	Cause (Disease or injury							
o,	be executed siclan and burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	ience of):					
8760	nte be nysick ne bu	dicai								
9	artifica ing ph eas ti	Med	IF FEMALE:							
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23d. Date of del	ivery Day Year
0	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	ath 5∐	Other (specify)				,
o.	res that the de signed by the a be detached f	/ Ph	Part II. Other significant conditions con	tributing to death but not resu	ilting in the un	derlying cause give	n in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Sp.	uires sign ld be		recurren	t Pneum	onia			1 ☐ Yes	2 No 3 Pr	obably 4 💇 nknown
<u> </u>	w require s been si should b	Completed						24a. Was an	24b. Were at	itopsy findings available
Re	The lav te has age 2	omp						autopsy performed	prior to death?	completion of cause of
ta		0	25. Was case referred to medical				26. Place of Death	(Check only one)	No 1 ☐ Yes	20 No
<u>></u>	Attending Physicien: It death. ector: After this certific by the funeral director,	To B	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 I	ER/Outpatient	3□ DOA Othe	1: 4 Nursing Hom	ne 5 🗆 Residence	e 6 □Other (Spe	cify)
0	ding Pt. th. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe how i	njury occurred	
Sio	r Attendii er death. rector: A by the fu	catio	2 Accident investigation 3 Suicide 6 Could not be				′es 2 □No			
Division of Vital Records,	= = c	Certification;	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	et, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Ru tate)	ırai Route Number,
	pit our:	edical C	(Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examinati	vledge, death ion and/or inv	occurred at the time	e, date and place, a inion, death occurre	nd due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	29d.	Date signed (Monti	h, Day, Year)
	F ≥ F 8) Wonsolp	Efhi	MD					
•	3		30. Name and address of person who cor		23a) (Type, F	Print)	55325		10041,	7
	1		WONSOCK SHI		Tan	1 Terra	ce Fro	stlying	M 1 2 153	12
	Sta	5.3	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	Rad.		V		
	Registr	ar	FEB 2 3 2	104	S. A					

			1 - For State Registrar AM:ND ITEM	State of #30 PER DV	of Marylar R G828 2/	nd / Depa /23/04 /\$#	artmeni <i>rtificate</i>	t of Healt e <i>of Dea</i>	th and M ath		giene Reg. No.	200)4	05555
			Decedent's Name (First, Middle		0020 27	20, 0 , 0				2. Date of Dea	ith			Time of Death
	Physicia		Plandorn	Jones)					Month O Z	Day	20c		3:00 PMM
	/Medic		4a. Facility Name (If not institution	n, give street and no	um ber)		4b. City, Town, or Location of Death				4c.	County of D		
			Future Care C	anton				altimor						
	Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 74	. last birthday) Yrs.	If Under Months		nder 24 Hrs. urs Min.	8. Date of Birtl (Month, Day Apr 6,	Year)	9.	Birthplece Country)	(State or Foreign
	Director		409-40-6742 Usual Residence of Decedent	1	/ 4					Apr 0,	1943		IN	
land	Mo 11		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation	-					10d. lr	nside City Limits
Many	e je	ţō	MD			Balti	imore						1	X Yes 2 □ No
ed) r	r 28e Inotii	Director	10e. Street and Number				10f. Zip	Code			10g. Citiz	en of What	Country?	
h wit	23a o	<u>e</u>	4716 Wilern	Avenue			21215				USA			
deet	E I	Funeral	11. Marital Status	Marital Status 12. Was Decedent Ever in U.S. Amped Forces?					c Origin? (Spe xican, Puerto	ecity Yes or No-	1	4. Race - A	merican In	ndian,
after	or Ite	F	1 ☐ Never Married 2 ☐ Mar	ned 1 2 Yes	2 🗌 No		1 ☐ Yes 2	_		riioari, oto.,		Specify:		ack
Sours	Eral.	d by	3 ☐ Widowed 4 🕅 Divorced	Year or	Dates:									
72 4	natu	Completed	15. Deceder (Specify only highe	nt's Education st grade completed	1)	(Give	kind of wor	l Occupation k done during	most of worki	ing unk	16b. Kir	nd of Busine	ess/Industr	y unk
ı ja	than	ш	Elementary/Secondary (0-12) unk	College unk	(1-4or 5+)	me. L	DO NOT us	e retired)						
ied h	Hygie ther t nt, in		17. Father's Name (First, Middle,					ınk 18. M	Iother's Name	e (First, Middle,	Maiden .	Sumame)		unk
should be filed within 72 hours after deeth with the Maryland	Department of Health and Mental Hygiene. Importent: fritems 23e or 28e-f show Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Madical Examinat must be notified at once.	Be c	The state of the s				`	ariic (s		7, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,				unk
hou	mark mati	To	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	ng Address	(Street and Nu	ımbər or Rura	al Route Numbe	r. City or	Town, Stat	e, Zip Cod	/e)
1d 2 s	Ith ar 27 is r trau		Future Care C							e Balti			2122	
, <u>a</u>	Hea tem other		20a. Method of Disposition		20b.	Place of Dispo	sition (Nan	ne of		Date	20c. Loc	cation - City	or Town,	Stete
age 2	ant of t: If i		1 Burial 2 Cremation 4 Donation 5 Other (5		State	cemetery, cren	matory or o	mer place)	i					
it.	artm order injur		21. Signature of Euneral Service		1.	22	. Name an	d Address of F	acility ,	655 W.	~ -		~	
9 5	Depar Impor		Ronald	age	Directo	r St Ba	ate A	natomy re, MD	2120		Ba1	timore	e Str	eet
H			23a. Pen 1. Enter the disease, o	complications that	caused the dea	ith. Do not ente	er the mode	e of dying, such	h as cardiac c	or respiratory are	rest,		App	roximate rval Between
Dh	ysician		shock, or heart failure. List Immediate Cause (Final	\cap		1 0							Ons	set and Death
h	Medical		disease or condition resulting in death)		o (or as a consec								46	an
E	kaminer													
- T		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a consec	quence of):								
cuter	nd trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initieted events	c	c									
e be exe	ian a urial-	E	resulting in death) Last	Due to	o (or as a consec	quence of):								
cate be executed	physician and the burial-transit	dlcal		d										
	ing p	0	IF FEMALE:											
ath cer	or us	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregn birth 2 ☐ Fet	el death 3 □	Ectopic pr				2	3d. Date of Month	delivery Day	Year
. e	the a	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Preg 9⊟Unki	gnant at time of one of the contract of the co	death 5	Other (sp	ecify)					,	
Physician: The law requires that the death certifu	been signed by the attending p should be detached for use as		Part II. Other significant conditi	ons contributing to	death but not re:	sulting in the ur	nderlying ca	ause given in P	Part I.	23e. Did to	bacco us	se contribut	e to the ca	use of death?
requires t	signe d be	d by		ctuer Bul		Dèin	, ,			1 🗆 Y	es 2[No 3□	Probably	4 Unknown
9	peen	Completed	Ide MARKE C											
e lan	2 23	Пp	140	. 1						24a. Was a autop perfor	sy		to complet	indings available tion of cause of
1 Th	icate r. pag		Peptic Ulcar To							1 Yes	2 🖸 No		/es 2□	No
VIE	eath. Ior: Atter this certificate has be the funeral director, page 2 s	Be	25. Was case referred to medica examiner?	Hospital:	31	3500		Other		(Check only or				
2 4	ralo	. To	1 Yes 2 No	28a. Date		ER/Outpatien		Bc. Injury at	~	me 5 Resid			Specify)	
ding.	h. Afte fune	tlon	1 Natural 5 ☐ Pendi	/1/0	nth, Day Year)	Injury	м	Work? 1 ☐ Yes						
Atten	deal ctor	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	e of Injury - At h	nome, farm, str	eet, factory	, office		28f. Location (S		Number or	Rural Rou	ıte Number,
5 5	after Dire	erti	4 Homicide	buile	ding, etc. (Speci	ify)				City or Tow	n, State)			
spite	nere nere		29a. Certifier 1 Certifyi	ng Physician: To th	ne best of my kn	owledge, death	occurred a	at the time, dat	e and place,	and due to the c	ause(s)	and manner	r as stated.	
To the Hospital or Attending	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical one)	Examiner: On the and ma	basis of examin nner stated.	ation and/or inv	vestigation,	in my opinion,	death occurr	ed at the time, o	late and	place, and	due to the	cause(s)
Toth	To the	M	29b. Signature and title of certifie	120-			29c	License numb	ber	2	29d. Date	signed (M	onth, Day,	Year)
			phread for	was in			D	19667			02-	190	2000	4,
			30. Name and address of person	who completed car	use of death (Ite	m 23a) (Type,	Print)							
					JRE CARE (BALTIMO	RE,MD.						
	Sta		31. Date filed (Month, Day, Year	329	Registrar's Sign	le A.	100							

State of Maryland / Department of Health and Mental Hygiene 2004 05556 State AMEND ITEM #23a&b PIR PHY G828 2/23/Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Jackson 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mary land Medical Baltmove If Under 1 Year | If Under 24 Hrs. Aniversity 5. Social Security Number 6. Sex. 1 M 2 □ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Days 216-20-7028 Months Director 08-04-1926 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 XYes 2 ☐ No N/A BALTIMORE Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 238 2603 PUGET STREET 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) at Hygiene. Pages 1 and 2 should be filed w timent of Health and Mental Hygie tant: If Item 27 is marked other ti jury or other traumatic event, It. INDUSTRY GLASS OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HURBY JACKSON FRANCES HAYS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATTI ANN JACKSON, DAUGH, 108 N. ALLENDALE ST, BALTIMORE, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of important: If any injury or once. MOUNT ZION 02-19-04 MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME K 100 well 4600 LIBERTY HGHTS AVE, 21207 BALTO, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MCUMONIZ-ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a onsequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been signing page 2 should be 2 X No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2**X** No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Inpatient 2 ER/Outpatient 3 DOA ical Certification: To this Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide after within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) BONUM, M.D 15092 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.O. Stephynie Borum S. Green Street Baltimore MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 3 2004

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			1 - For State Registrar	State of Mary	rland / Depa <i>Cei</i>	artment of He rtificate of D	ealth and M Death		Reg. No.	004	0555
н	Physic	ian	Decedent's Name (First, Middle, La	ist)				2. Date of De Month	aath Day	Year	3. Time of Death
	/Medi		Robert				Jones	Febru	y 15	2004	1741 PM
)	Exami	ner	4a. Facility Name (If not institution, give	re street and number)		4b. City, Town, or I	Location of Death	./		ty of Death	
			The Johns Honk 5. Social Security Number 9 6.5			Baltimo		<u>y</u>		/A	
j.	Funeral Director			Sex 7. Age (In 1 1 Mg M 2 □ F 7 2	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	19 , 1931	Coun	
-			212 26 5517 Usual Residence of Decedent	12				MAK. C	79,193.	MAR	YLAND
	nylan how		10a. State 10b. County	10	c. City, Town or Lo	cation				1	0d. Inside City Limits
	e Ma	Director	MD. N/A		BALTIN	IORE					1 XYes 2 No
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	23s		1401 E. OLIVE	ER STREET		212	13		U.S.2	Α.	
	tems er m	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces? ▼ Yes 2 No	in U.S. 13. \	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe	cify Yes or No	- 14. Ra	ice - Americ	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23a or 28a-1 show event, tra Medical Examinar must be rectified at	by	1 Never Married 2 Married 3 Widowed 4 Privorced	IX Yes 2 □ No I If Yes, Give Year or Dates:	JUNE, 195	52Yes 2₽No	Specify:			bla	
'n	72 h	ete	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Deced	lent's Usual Occupat kind of work done du	tion uring most of working	na	16b. Kind of E	Business/Ind	lustry
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N	filed v Hygie other t	ပိ	8 TH 17. Father's Name (First, Middle, Last		STE	ELWORKER			BETHI		l
au		Be	ARTHUR JONES	,		1	18. Mother's Name SUSIE I		Maiden Sumai	me)	
Š	should be filed nd Mental Hygii marked other imatic event, II	ဥ	19a. Informant's Name/Relationship (Tuna Printl	105 14-15-	- 111					
<u> </u>	2 8 5 8	B				g Address (Street an					_
ā,	1 and Health tem 27		GEMINI THOMPS 20a. Method of Disposition		Oh Diese of Diese		h street	t BALT	20c. Location		
<u>o</u>	0 0		MSgyrial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cren	natory or other place)	FEB. 2	7,2004	200. Location	· City or To	wn, State
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ñ	permit. Departimonts Imports any inj		1881 mudine	5/ Arke	CA	Name and Address	SCRUGGS	S FUNE	RAL HO	OME	
	Tire		23a. Part1. Enter the disease, or com	plications that caused the		12 E. PI	RESTON S	ST. BA	L'I'O, MI		213 Approximate
	Physician		Immediate Cause (Final	one cause on each line.		,		respiratory at	1001.		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a cor		emorrage	2			5	even Dys
	Examiner			A la	Do act 1	مان ال					
Ą		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	rsequence of):	MIME				26	even by
	outed ansit	Examiner	Cause (Disease or injury that initiated events								
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õ	ng pt	Med	IF FEMALE:								
DOX	res that the death certi igned by the attending be detached for use a	hysician/M	23b. Was decedent pregnant	23c. If yes, outcome of pr		Ectopic pregnancy			23d. Da	te of deliver	у
	e dea he at	sici	in the past 12 months? 1 Yes 2 No	4□Pregnant at time 9□Unknown		Other (specify)			Mo	onth [Day Year
ŗ	at the	Phy	9 □ Unknown								
<u>ທ</u> ົ	igned be d	by	Part II. Other significant conditions of			derlying cause given	in Part I.	23e. Did to	bacco use cont	ribute to the	cause of death?
ecords,	law requires as been sign 2 should be	ted	Hypotension,	Seurgenie	shock_			1 🗆 Y	es 2 No	3 Probal	bly 4 Whknown
	law lasb	Completed						24a. Was a		Were autops	sy findings available
	The sate h	Con						perfor	med?	death?	plation of cause of
VII I	rsician: The law s certificate has b lirector, page 2 s	Be (25. Was case referred to medical examiner?			2	6. Place of Death				
5	hysik his a	2	1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatient	3 DOA Other:	4 Nursing Hom	e 5 🗆 Resid	ence 6 □Oth	er (Specify)	
=	ing P	- Lo	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	28c. Injury at Work?	t 28	3d. Describe h	ow injury occurr	ed	
NISION	eath.	cati	2 Accident investigation			M 1 TYes	s 2 No				
<u> </u>	or At fter d yirect in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - i building, etc. (Sp	At home, farm, stre ecify)	et, factory, office	28	3f. Location (Si City or Town	treet and Numb n, State)	er or Rural I	Route Number,
	ortal urs a ral C										
:	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledicai	29a. Certifier (Check only one) Certifying Physical Example (Check only one)	ysician: To the best of my iner: On the basis of exam and manner stated.	knowledge, death nination and/or inve	stigation, in my opini	on, death occurred	nd due to the cand at the time, d	ause(s) and ma ate and place, a	nner as stat and due to th	ed. he cause(s)
ı	To Too	Σ	29b. Signature and title of certifier	100		29c. License n		2	9d. Date signed	(Month, Da	iy, Year)
	is a		James	CLEMO		RES	-000	F	ebrucy	15,5	2004
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			James O. Madd,	completed cause of death (Tohns Hap kins) 32. Registrar's S	450As1 60	20 North L	Jolfe Street	et, But	time M	aslan.	1 21287
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	gnaturè	H. Local					
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Privation (March 1997) Copyoint Name of Private Continues of Private				For State Registrar	State of Maryland	/ Depa	rtment of Health a tificate of Death	nd Mental H	ygiene Reg. No.	2004	05558
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Transmission Tran	ı	Funeral		5. Social Security Number 6. S	7. Age (In yrs. las	st birthday)		4 Hrs. 8. Date of B	irth	9. Birth	place (State or Foreign
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Dongson S Done (Speech)	ē,	of Hea item		20a. Method of Disposition	20b. Pla	ce of Disponetery, cren	sition (Name of natory or other place)	Date	20c. Lo	ocation - City or 1	Town, State
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State		- 01-		31. Date filed (Month: Day, Year)	32. Registrar's Signatu	TAM)	MONDS (TORK	y Rel 1	5/12	D MD	diri)
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State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 1647 M **Physician** Kalstein a 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital HOWARD COLUMBIA. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 19, 1938 Birthplace (State or Foreign Country)
PA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 100 M 20 F 65 Yrs. 578-52-3849 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or then "naturel", or items 23e or 28e-f show The Medical Examiner must be notified at 1 Yes 2 10 Ellicott City Director Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 8700 Ridge Road, Apt. 405 United States within 72 hours after death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Maryland 21215-0036 If Yes, Give Year or Dates: 3 ☐ Widowed 4 M Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Automobile al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Salesman traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental | Int: If Item 27 is marked o Morris M. Kalstein Beatrice Svlvia Beloff 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Lisa Scott/Daughter 8103 Escalm Avenue, Pasadena, MD 21122 other Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Feb 21 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 0 permit. Page Department o Important: If eny injury or Chesapeake Crematory Beltsville, MD 4 □ Donation 5 □ Other (Specify) 2004 22 Name and Address of Facility Cremation and Funeral Alternatives 21. Signature of Funeral Service Licens DOCe. M00986 8717 Green Pastures Drive Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Septic Shock Immediate Cause (Final and Sepsis 24 hrs **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Renal failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit neumonia Due to (or as a consequence of) Physician/Medicai as the attending IF FEMALE 951 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 5 Other (specify) ☐Yes 2☐No Records, P.O. the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to be det þ Congestive heart 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 certificate 1 Yes 2 No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: After Injury To the Hospital or Attending 1 Natural 5 Pending within 24 hours after use....
To the Funeral Director: After the funeral pipe for the funeral 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Thme 20060345 waiser) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway Columbia MD 21044 10724 little Patuexant alsex A. Ahmad. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05560 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** February 19, 5:45 A M 2004 William Sturtevant Kennedy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Cherrywood Nursing Home Reisterstown Baltimore | Months | Days | Hours | Min. | Sep 7, 19 9. Birthplace (State or Foreign Country) Connecticut 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 MM 2□F 78 yrs. 048-12-8907 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28e-f ehow the Medical Exertinent rust be notified at 1 Yes 2 No Director Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 27 Wickham Court 21136 United States or Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: ; W.W.T 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 Widowed 4 Divorced "naturel", WWI Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Social Security permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 ie marked other the any injury or other treumatic event, Ite ance. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Worthy Chester Kennedy Dorothy Sayward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sali K. Kennedy/Wife 27 Wickham Court, Reisterstown, MD 21136 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Feb 21 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives ul. 8717 Green Pastures Drive Baltimore, 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Porhinson's Die use /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. ed by the attending physician detached for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 5 Pending investigation 1 Natural
2 Accident death. 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospitel o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12905 My alexan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 COURT Allen C-C1

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrate Signature

1 2004

			For Stata Registrar	State of Maryland / De	epartment of li Certificate of	Health and M Death	Mental Hyg	iene 20	04 05561
	Physicia	an	Decedent's Name (First, Middle, Last) MORRIS	LA	FFERMAN		2. Date of Deat Month February		ear 5:15 A+M
	/Medic Examin		4a. Facility Name (If not institution, give str KESWICK NURSING HO		BALTI		,	4c. County of N/A	Death
	Funeral Director		218-07-7280 X	7. Age (In yrs. last birth	Months Davs		8. Date of Birth (Month, Day, JAN 19,	Year)	P. Birthplace (State or Foreign Country) PENNSYLVANIA
	Maryland f show	tor	Usual Residence of Decedent 10a. State MD 10b. County N/A	10c. City, Town o	or Location TIMORE				10d. Inside City Limits 1
	with the 1 3a or 28a-	Funeral Director	10e. Street and Number 3211 CLARKS LA., AP	T. 220	10f. Zip Code 212	15	1	0g. Citizen of Who	at Country?
036	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other then "neturel", or Items 23a or 28a-f show event, I'te Madical Examinar must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 _Yes 2 _No If Yes, Give year or Dates:	13. Was Decedent of If Yes, specify Cult		ecify Yes or No- Rican, etc.)		American Indian, White, etc. WHITE
21215-003	C 100	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) (Decedent's Usual Occu Give kind of work done life. DO NOT use retin DRIVER	e during most of work	ting	16b. Kind of Busin	
ğ	should be filed within the Mental Hygiene. I marked other then umatic event, the Mental Ment	To Be C	17. Father's Name (First, Middle, Last) ABRAHAM	LAFFERMAN		18. Mother's Nam	(COHEN	
	ges 1 and 2 should t of Health and Men If item 27 Is marke or other treumatic		19a. Informant's Name/Relationship (Type MRS. PHYLIS SCHUCH		Mailing Address <i>(Stree</i>			; City or Town, Sta ALTOMD	
altimore,	Pages 1 a nent of Hei int: If item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Rei 4 Donation 5 Other (Specify)	20b. Place of E cornetery,	Disposition (Name of crematory or other place) EMUNAH (AI	ace)	Date	20c. Location - Ci	
Baltir	permit. Page Department Importent: If any injury o		21. Signature of Funeral Service License	2	22. Name and Addr		OL LEVIN	SON & BR	OS., INC.
	Physician /Medical Examiner		23a. Part1. Enter the disease, of domplications, or heart failute. List enty one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do no cause on each line. TS Chame Car Due to (or as a consequence of CHAMAY AV	tenter the mode of dy distribution of distribu	ing, such as cardiac op athy when the case	or respiratory arro	est,	Approximate interval Between Onset and Death 16 YEARS
8760,	Attending Physician: The law requires that the death certificate be executed redeath. redeath. redeath. by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of					,
O. Box 6	that the death certificated by the attending phase detached for use as to	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date of Month	
ds, P.	uires that I signed by Id be deta	ρ	Part II. Other significant conditions control. LICK JUNES S						ute to the cause of death?
Il Records,	ilcian: The law require certificate has been si rector, page 2 should b	Completed	maker- Cereb	nonaveulour	disease	2	autops	ned? dea	re autopsy findings available or to completion of cause of ath? Yes 2 \sum No
r Vita	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	spital: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 DOA	26. Place of Deat other: 4 ursing Ho		ence 6 □Other	(Specify)
Division of Vital	nding Physath. r: After this e funeral di	ation:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tin	ury W	ury at ork? □ Yes 2 □ No	28d. Describe ho	ow injury occurred	
Divis	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	Э	28f. Location (St City or Town	reet and Number n, State)	or Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Director Completely filled in the Complet	Medical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medicel Exemine	cien: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the for investigation, in my	time, date and place, opinion, death occur	and due to the cared at the time, d	ause(s) and mann ate and place, and	er as stated. d due to the cause(s)
	To th Vithir To th	Me	29b. Signature and title of certifier M - Habelle Va	e Ano Der OT D		nse number 3657		4	Month, Day, Year)
	D		30. Name and address of person who con	pleted cause of death (Item 23a) (TRECORTON)			TIMODE	0721	211
	Sta Registr		31. Date filed (Month, Grandsar) 2 3	2004 32. Registrar's Signature	Soule	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05562 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Clarence Muhammad 00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Butimore City trenera Maruland 8. Date of Birth (Month, Day, Apr 5, Birthplace (State or Foreign Country) 5. Social Segurity Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1X M 2□ F 578-42-1951 69 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir then "natural", or Items 23e or 28a-f ehow The Medical Examiner must be notified at MD Baltimore 1 Yes 2 □ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4601 Pall Mall Road 21215 USA unk 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritat Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. I be important: If item 27 is marked other then "natural; or Itel any injury or other traumatic event 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) unk Coltege (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maryland General Hospital 827 Linden Avenue Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 🖾 Other (Specify) in state 21. Signature of Eune al Service Licensee Ronald Sx Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director 7 and Baltimore, MD 21201 23a. Park shock . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neu mori resulting in death) /Medical Due to (or as a consequence of): **Examiner** Cance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by filiency Virus, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 DNo 1 Yes completely filled in by the funeral director 25. Was case relerred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? after death. 28d. Describe how injury occurred 1 PNatural 5 Pending investigation м 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I the Hospita 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. -Canadenle 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Educardo Minelas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) General Hospita Eduardo 10 31. Date liled (Month, Day, Year) 32. Registrar's Signature State FEB 2 3 2004 Registrar

		1	_ State	tate of Maryland / D	epartment of Health and I Certificate of Death	Mental Hygie Reg.		05563
	Physicia	in	Registrar Decedent's Name (First, Middle, Last)	Miller		2. Date of Death	Day Year	3. Time of Death 3:10 P. M
	/Medic Examin		La. Facility Name (If not institution, give stree Greater Baltimore M		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Ť	Funeral Director		6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2□F 7. Age (In yrs. last birth			9. Birthple 1931 Man	ace (State of Foreign
	Maryland f show		Jsual Residence of Decedent 10a. State 10b, County AD BOTTON	10c City, Town	411		10	od. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23s or 28s-f show f mast be notified at	Funeral Director	10e, Street and Number 9710 Emge Ro	d.	10f. Zip Code 21234	10g.	Citizen of What Count	ry?
36	rurs after death with the Manylan al', or Items 23a or 28a-f show Examilier mast be notified at	by Funera	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - America Black, White, e Specify: B/Q	
[CCV]	in 72 ho n "natur	Completed to	15. Decedent's Education (Specify only highest grade co	on 16a.	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)		b. Kind of Business/Ind	ustry
) (Jund 213	D D	Be	17. Father's Name (First, Middle, Last)	F	18. Mother's Na	me (First, Middle, Mai	den Sumame)	
Miller Saltimore, Maryland		2	19a Informant's Name/Relationship (Type,	Print) 19b,	Mailing Address (Street and Number of R.	ural Route Number, C	ity or Town, State, Zip	Code) 1215
nore, I	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 Paurial 2 Cremation 3 Rem 4 Donation /5 Other (Specify)	oval from State	Disposition (Name of y, crematory or other place) ational Mem . 2 - 2	Date 200	c. Location - City or Tov	wn, State
Baltin	permit. Pa Departmen Important: any injury once.		21. Signature uneral Service Lice is		22. Name and Address of Facility Gary P. March FIH	270 Fre	thilten Pa	<u>SS</u>
	Physician		23a. Part1. Enjor the disease, or complication of heart failure. List only one of immedials Cause (Final	ions that caused the death. Do rause on each line.	not enter the mode of dying, such as cardia	c or respiratory arrest		Approximate Interval Between Onset and Death
	/Medical Examiner		disease of condition resulting in death) Sequentially list conditions, b. —	Due to (or as a consequence	of):	na Cava	Throwhos.	, Years
No.	ecuted and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events coulding in death) Last	Due to (or as a consequence				
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O. Box 6	eath cer attendir for use	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □ Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ny Day Year
ds. P.	uires that the signed by	d by Ph	Part II. Dther significant conditions contrib	buting to death but not resulting in	n the underlying cause given in Part I.		cco use contribute to th	
Division of Vital Records. P.O.	he law req e has beer age 2 shou	omplete				24a. Was an autopsy performe	24b. Were autoprior to condeath?	psy findings available inpletion of cause of
E	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?			ath (Check only one)		
of \	Physic r this c	P	1 Yes ZigNo		Time of 28c. Injury at	Home 5 Residence 28d. Describe how	e 6 ⊡Other (Specify injury occurred	")
io	ath. r: After	atior	2 Accident investigation	NA	M 1 ☐ Yes 2 ☐ No	NA		
Sivic	a # # = =	Certification;	3 Suicide 6 Could not be determined	28e. Płace of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
d	Hospita 4 hours Funeral	edical Co	(Check only 2 Medical Examine)	: On the basis of examination ar	e, death occurred at the time, date and place nd/or investigation, in my opinion, death occ	e, and due to the causurred at the time, date	se(s) and manner as st a and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.	29c. License number	290	Date signed (Month,	Dey, Year)
	2		30. Name and address of person who comp	bleted cause of death (Item 23a)	(Type, Print) PO BOX Y	52 Tim	longum M	0 21091
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature				

Registrar

DHMH 17 Rev 1/2001

FFP 2 3 2004

2. Registrar's Signature

B. Abach

State of Maryland / Department of Health and Mental Hygiene 2004 05564 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 4:10 PMM February 2004 William DeMarco Mayo /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4648 Norrisville Road White Hall Harford If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1**K** M 2□ F 213-30-0287 74 Yrs. Dec 18, Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 € No MD Baltimore White Hall Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4648 Norrisville Road items 23a 21161 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, Ita Medical Examinal page. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White **'**54**-**56 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk College (1-4or 5+) Elementary/Secondary (0-12) 12 4 engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edith Gorsuch George Mayo ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4307 Green Glade Road Phoenix, MD 21131 Carolyn Mayo/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State `4 X Donation 5 ☐ Other (Specify) 21. Signature of Fu eral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 dell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on early line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 100 **Physician** 104 /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? 1 Yes 2 No funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 1 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours a To the Funeral D To the Hospital filled ⊯ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and no completed cause of death (Item 23a) (Type, Print) 30. Name and address of 32 Registrar's Signature 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar

3 2004

State of Maryland / Department of Health and Mental Hygiene 2004 05565 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Schnany 18 2004 romen /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town or Location of Death Examiner 7. Age (In vrs. last birthday 8. Birthplece (State or Foreign **Funeral** Days Country, 1 M 2 F Hours Director 1 - 8 - 24214-26-7838 80 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-1 show the Medical Exeminer must be notified at 1**√**Yes 2 No Md. Director NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 1634 N. Broadway 21213 USA Items 23a by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 naturel, or 1 ☐ Yes 2 ☑ No Specify: Black 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry na most of working 12 should be fited within 7 h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Nurses Assistance Johns Hopkins Hosp. 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked of any injury or other traumatic ew since. Williams Ida Williams Williams 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Montgomery Sister-in-law 4036 Salem Bottom Rd., Westminister, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore Cem. 2-24-04 Baltimore, Md. Ignati re of Funeral Service 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dis e e or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran Iding physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by the 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by bdomydosis 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Renal Karture 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an autopsy lal or Attending Physician: The safter death.

Is Director: After this certificate ad in by the funeral director, par 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Matural 5 Pending Injury 1 Tes 2 No investigation 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeref L Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only onel the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who 32. Registrar's Signat 31. Date filed (Month, Day, Year) State Registrar FEB 2 3 2004

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			1. Decedent's Name (First, Middle, Las	st)				2. Date of De Month		Year	3. Time of Death
	Physicia /Medic	al	RITA	M. MASON				FEB	0 -	2004	12:10A M
	Examin	er	4a. Facility Name (If pot institution, give 6510 S. Charton	street and number) Road Apt. L		4b. City, Town, or Glen	Location of Dea Burnie	ith		ty of Death Arund	el Co.
244	Funeral Director		5. Social Security Number 6. S 220-01-5171 1	ex 7. Age (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th <i>y, Year)</i> 1921	9. Birthp Coun Mary	lace (State or Foreign try) 1and
			Usual Residence of Decedent	10.00							0d. Inside City Limits
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	with ti		10e. Street and Number Charter Ro) T		10f. Zip Code 21061			-	S.A.	uy:
	ns 23	eral	6510 S. Charton 11. Marital Status	12. Was Decedent Ever in U.S.	13. W	as Decedent of Hi	spanic Origin?	Specify Yes or No	- 14. Ra	ace - Americ	
36	should be filed within 72 hours after death with the Maryland and Mentla Hygiene. a marked other than "natural", or ttems 23a or 28a-f ahow a marked other than "natural", or ttems 23a or 28a-f ahow umetic event, I're Medical Eraminer must be notified at	by Funeral	1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give A Year or Dates:	lf	Yes, sp <i>ec</i> ify Cuba ☐ Yes 2 ☑ No	n, Mexican, Pue Specify:	rto Rican, etc.)	Spec	ack, W hite, ify: Wh	etc. ite
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and	itd be file lental Hy ked oth ic event	To Be (17. Father's Name (First, Middle, Last) Michael	Quinn			Rose	ame (First, Middle	Maiden Suma Hatha		
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Heatils and Menta Important: If item 27 is marked eny injury or other traumetic et <u>pnce</u> .		19a. Informant's Name/Relationship (Ruel Mason		6510	S. Chart	en Apt	Rumi Route Numb L Glen	er, City or Tow Burnie	n, State, Zip , Md .	21061
<u>ရ</u> ်	Heal Heal tem 2		20a. Method of Disposition	20b. Place	of Dispos	ition (Name of atory or other place		Date	20c. Location	- City or To	wn, State
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Baltimore,	Departm Departm Importar eny injur		21. Signature of Funeral Service Licer		22.	Name and Address MCCUIII	y Polyn:	iak Funer Lo Ave. H	al Hom	e P.A.	. 21225
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a F				1				1 ☐ Yes	212 No 1	1 🗆 Yes	2/2 No
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State of Maryland / Department of Health and Montal Hygion

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ary	shou and M and M	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing Address (Stree	t and Number or Rure	el Route Number,	City or Town,	State, Zip	Code)
	and 2 paith a 27 is	Annett Mucci	(daughter)	2963 Rose Cr	own Circle	. Pasade	ena. MD	2112	2
ore	as 1 end of Health of Item 27 r other to	20a. Method of Disposition 1 □ Burial 2 ☑ Cremetion 3 □ R	20b. I	Place of Disposition (Name of cemetery, cremetory or other place	ice) F	eb ^{Pate} 23	20c. Location -	City or Tov	vn, State
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Baltimore,	permit. Paga: Depertment of Important: If I any injury or once.	21. Signature of Puneral Service License	е	22. Name and Addr		Stalling	s Fune	ral H	ome, P.A.
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on	D par C	1 Natural 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Year)	Injury Wo	rk? Yes 2 □ No	200. Describe nov	w injury occurr	Bu	
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_	/ /	Da feet Single	Sidhu	1413 Annaha	lis Koal	1 #10	6 000	entor	, IMD HIG
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Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05568 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** FEBRUARY 18, 2004 MILLER 1:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CENTER TOWSON BALTIMORE 8. Date of Birth (Month, Day, Year) AUG. 27, 1925 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Months Days Hours Yrs. MD 78 217-32-7851 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4001 OLD COURT ROAD, APT. 400 21208 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 \\ Yes 2 _ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married ö 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) PROPRIETOR TRUCK SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ages 1 and 2 should be find of Health and Mental H MILLER **BLANCHE** CHINN FI I ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4001 OLD COURT ROAD - BALTIMORE, MD 21208 MILDRED MILLER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. BETH EL MEMORIAL PARK 2/20/2004 RANDALLSTOWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee, 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) months CANCER **Physician** Una /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier February 18, 2004 NO 30. Name and address of person who completed cause of death (them 23a) (Type, Print) N. Charles St. Baltimore, Md 21204

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's signature

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 2004 William E. Osbourn, Jr. - GB /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD BEL A IR If Under 24 Hrs. HEALTH MARINE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1**X** M 2□ F 84 06/21/1919 216-01-9860 Maryland Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a, State rail, or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director MD Harford Forest Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 306 E. Willrich Circle U.S.A. 21050 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW I 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WW II White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) then College (1-4or 5+) 12 Toolmaker and Machinist Manufacturing Ind. other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fili Department of Health and Mental Hy Important: If Item 27 is marked oth sny injury or other traumatic event Be William E. Osbourn, Sr. Carolyn Shook ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth B. Osbourn (wife) 306 E. Willrich Circle - Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 02/20/2004 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licenses ass als 11750 Belair Road - Kingsville, MD Approximate Interval Between Oriset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Phrumonia Mays **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. the attending physician Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months? should be detached for 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed' 1 ☐ Yes 2 No of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Be Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral 27 Manner of Death 1 Natural 2 Accident 5 Pending 1 Tyes 2 No death. investigation after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the Funeral (completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Scot 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar 2004

DHMH 17 Rev 1/2001

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		•	1 - For State Registrar	State of Mar	yland / Dep Ce	ertificate of	lealth and M Death	lental Hygie	ene 200L	05570
	Physici /Medic		1. Decedent's Name (First, Middle, Last) $\label{eq:decedent} {\tt James} \qquad {\tt C} \ .$		eary Sr			2. Date of Death Month February	^{Day} 22 2004	3. Time of Death 1:15 AM
	Examin Funeral Director		4a. Fecility Name (If not institution, give s 108 Cloverhill Ro 5. Social Security Number 220-12-4994	oad	'In yrs. last birthda 80 Yrs.	Pa	r Location of Death Sadena If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day SSDt. 24	4c. County of Deat Anne A (ear) 9. Birth	
	ס	2	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar	1	Oc. City, Town or		adena	0390. C.	1020	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the M 3a or 28a-f	i Director	10e. Street and Number 108 Cloverhill Ro			10f. Zip Code	21122	10g). Citizen of What Co USA	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other than "natural, or items 23s or 28s-f show marked other than "natural, or items 25s or 28s-f show maile systit, the Medical Examiner must be notified at	by Funerai		12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	er in U.S.	. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	ncan Indian. a. etc. hite
Maryland 21215-0036	filed within 72 hou Hygiene. Ither than "nature int, "to Wedical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Dec (Giv life.	edent's Usual Occup e kind of work done DO NOT use retired	pation during most of working ction	į.	Building	Industry
yland 2	ould be filed Mental Hygiarked other atic sysnt,	To Be Co		_eary			18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
	and 2 she ealth and m 27 is m		19a. Informant's Name/Relationship (Type Elizabeth V. O'Lea	ary (spous	se) 108	Cloverhi	11 Rd., P	asadena,		
altimore,	permit. Pages 1 and 2 should be Department of Health and Menia Important: If Item 27 is marked sny injury or other traumatic as 800.8.		20a. Method of Disposition 1 Burial 2 X Cremation 3 Review 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lieurese	emoval from State	Metro Cr	position (Name of ematory or other place) Cematory I Can be and Addre	nc. 20	25 04 Ba	c.Location-City or	Maryland
Ba	perm Depa Impo sny i		23a. Part1. Enter the disease, or complic	41).		3111 Mou	ntain Roa	d, Pasade	na, MD 21	Home, P.A. 122
£	Physician /Medical Examiner by sician and provided Examiner the party francist	Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a control of the contr	consequence of):	menting	tenorda	ruses		Interval Between Onset and Death Conset and Dea
P.O. Box 68760,	The law requires that the death certificate be tte has been signed by the attending physicis page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1	Fetal death 3	□Ectopic pregnancy	/		23d. Date of deliment	very Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions con	hageal) Keff	underlying cause giv	en in Part I.	10	cco use contribute to 2 ☑ No 3 ☐ Pro	the cause of death?
tai Rec	hysician: The law his certificate has b I director, page 2 st	e Completed	Hypertern 25. Was case befored to medical	reelite			26 Place of Death	24a. Was an autopsy performed	d2 prior to c death?	topsy findings available ompletion of cause of
Division of Vital Records,	ding Pl	ation: To Be	examiner? I Yes 2 No H 27. Manner of Death Natural 5 Pending investigation	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpation 28b. Time (ear) Injury	of 28c. Injury Wor	26. Place of Death er: 4 \sum Nursing Hor y at k? Yes 2 \sum No	· · · · · · · · · · · · · · · · · · ·	e 6 □Other (Specinjury occurred	ify)
Divis	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. ((Specify)			City or Town, S		
	To the Hospitel or within 24 hours after To the Funerel DII completely filled in	Medicai	29a. Certifier 1. Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of r ner: On the basis of en and manner states	kamination and/or	ith occurred at the tin nvestigation, in my o 29c. Licensi	pinion, death occurre	ed at the time, date	se(s) and manner as and place, and due Date signed (Month	to the cause(s)
	11		30. Name and address of person who con	mpleted cause of dea	th (Item 23a) (Type		7744	2	123/04	
秋	Sta	100	31. Date filed (Month, Day, Year)	CYMAT 32. Registrar's	Signature 4	Hospital	8. 63	arel >	1061	<u> </u>
	Registr	ar	FFR2 3 2004	1/ale	100	word				

State of Maryland / Department of Health and Mental Hygiene 2004 05571 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OWRUTSKY 1:16 PM HERMAN 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore City Singi Hospital of Baltimore N/A Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR. 27, 1926 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F Days Hours Min 216-28-9031 77 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 11202 VALLEY HEIGHTS DRIVE Items 23a 21117 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give WWII 1 Never Married 2 Married ò 1 ☐ Yes 2 📉 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) +2 than Elementary/Secondary (0-12) MANUFACTURERS REPRESENTATIVE **FURNITURE** other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be f **GRUBER** f Health and Menta Item 27 is marked LOUIS OWRUTSKY ROSE ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11202 VALLEY HEIGHTS DRIVE - OWINGS MILLS, MD 21117 SELMA OWRUTSKY / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM. 2/20/2004 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lig 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or c shock, or heart failure. List Immediate Cause (Final disease or condition 12 days **Physician** Interchio Tuocordial resulting in death) /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Cher (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑No 3 Probably 4 □Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ◯ No 24a. Was an Chronic Renal Failure autopsy performed 28 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 2 ER/Outpatient 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ebruary 18, 2003 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smai Hospital of Baltimore Jenniffer Adams Registrar's Signature 31. Date filed (Month, Day, State Registrar

Hiert Lown as Herman Courutski

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2004 05572 1 - For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 1-6-13 URIL Physician /Medical 4c. County of De. 4b. City_Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1 more URSIN 6 If Under 1 Year If Under 24 Hrs. S. Date of Birth Months Days Hours Min. Month, Day, Birthptace (State or Foreign Country) (In yrs. last birthday) 5. Social Security Number 6. Sex 7. Age **Funeral** 1 □ M Director Usuel Residence of Decedent 10d. fnside City Limits with the Maryland 10c. City, Town or Location 10b. County in then "naturel", or liems 23a or 28a-f show the Medical Examiner must be notified at 12 Yes 2 □ No Funeral Director 10g. Citizen of What Country? 10f. Zin Code death v 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, Whi permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If Itam 27 is marked other than "naturel", or item any injury or other traumatic event. The Martinum of the statement of the stateme 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coffege (1-4or 5+) 17 Fether's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Commiss ion 0 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Purial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses once. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Yes in by the funeral director, 25. Was case referred to medical examiner?

1 ☐ Yes = 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 31464 2/19/04 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Ball Inte 308 ST A. HASHM. 821 N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra 2004

State of Maryland / Department of Health and Mental Hygiene 2001

		1 - State Registrar Amend Item#4aperF 1. Decedent's Name (First, Middle, Last)	HYG8282/21/04 EW Ce	rtificate of Death	2. Date of Death	J. No. 3. Time of Death
Physicia		Charles	Price		February	7 17 2004 1900 p M
/Medic Examin	er	4a. Facility Name (If not institution, give stree	t and number) ospital	4b. City, Town, or Location of Lanham	f Death	4c. County of Death Prince Georges
Funeral Director		5. Social Security Number 6. Sex 18 M	7. Age (In yrs. last birthday 7 2 Yrs.	If Under 1 Year If Under 2	Min. Sept 1,	9. Birthplace (State or Foreign Country) Bronx, N.Y.
I ey, IVICAL Y ICATION ZELOCOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOO	To Be Completed by Funeral Director	1 Never Married A Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade contents) Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last) Isaac Price 19a. Informant's Name/Relationship (Type, Charles Price (Science))	Street Nas Decedent Ever in U.S. Armed Forces? Pyes 2 No tyes, Give Year or Dates: Korea Scollege (1-4or5+) Print) 19b. Mai 7 W	1phi 10f. Zip Code 20783 Was Decedent of Hispanic Originary If Yes, specify Cuban, Mexican 1□Yes 2 No Specify: Bedent's Usual Occupation e kind of work done during most DO NOT use retired) 18. Mother Maling Address (Street and Number est Walnut A	gin? (Specify Yes or No- i, Puerto Rican, etc.) t of working Engineer In Section 1 Engineer Woods er or Rural Route Number, (Ve. Mercha)	
permit. Pages 1 at Department of Heal Important: If item any injury or other pages.		20a. Method of Disposition 1 Burial 2 Cremation 3 Remo 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complements of condition resulting in death)	BGWCD ons that caused the death. Do not e	22. Name and Address of Facilit $1201 { t Dundalk}$	Feb. 24 A Kaczorowsk Ave. Balt cardiac or respiratory arres	rneytown, N.J. i Funeral Home, PA imore, Md 21222 Approximate Interval Between
	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last d	Due to (or as a consequence of): Due to (or as a consequence of):			-
The COLOGS, P.O. DOX 00/00, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
tuires that in signed by		Part II. Other significant conditions contrib	uting to death but not resulting in the	underlying cause given in Part I		acco use contribute to the cause of death? s 2 □ No 3 □ Probably 4 DUnknown
VI(a) NECOTOS, sicien: The law requires t certificate has been signe rector, page 2 should be c	Completed				24a. Was an autopsy perform	prior to completion of cause of
g Physicarthis	Certification; To Be C	2 Accident investigation	Dital: 1 Inpatient 2 ER/Outpate 28a. Date of Injury (Month, Day Year) 28b. Time Injury 28e. Place of Injury - At home, larm, building, etc. (Specify)	ent 31 DOA Other: 4 No ol 28c. Injury at Work? M 1 Yes 2		nce 6 □Other (Specify) w injury occurred set and Number or Rural Route Number,
LIVISION To the Hospitel or Attendin within 24 hours after death To the Funerel Director: Aft completely filled in by the fur	Medical Ce	29a. Certifier (Check only 2X) Medicel Exeminer 29b. Signature and title of certifier	an: To the best of my knowledge, de: On the basis of examination and/or and manner stated.	ath occurred at the time, date an investigation, in my opinion, dea	ath occurred at the time, dated	use(s) and manner as stated. te and place, and due to the cause(s) d. Date signed (Month. Day, Year) ebruary 18 2004

State

31. Date filed (Month, Day, Year) 32. Re FEB 2 1 2004

32. Registra Signature

who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05574 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 9:05AM ebruary 20 2004 /Medical 4b. City, Town, or Locetion of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner MAIN STREET KTON if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F ALABAMA 215-34-7093 Yrs. December 25,1906 Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 PYes 2 □ No Cecil ELKTON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? EAST MAINSTRECT 21921 150 Funerai 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: BLAZK 3altimore, Maryland 21215-0020 ρ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AGRICULTURE LABORER UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty MAIN STREET EULTON MP 21921 injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State oper tw 4 ☐ Donation 5 ☐ Other (Specify) Arend & Crew W 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility ANATON FIFTS Kgish uanta K DR 1490000 MD 20076 thomas 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attending physician and I for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Elevated þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1□ Yes 2XNo 1 ☐ Yes 2 ☐ No. al or Attending Physician: To sefter death. I Director: After this certificat 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other:
4 Nursing Home 5 Residence 6 XOther (Specify) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital o within 24 hours of To the Funeral Di 29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEM #18,20a-cx22 PER FIT G828 2/24/04/H 05575 Certificate of Death AMEND ITEM #30 PER DVR G828 2/23/04 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 200 4a. Facility Name (If not institution, give street and number) 8:25an /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth .Funeral Months Hours 1 □ M 2 🗓 F 92 214-20-4496 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD St. Mary's Lexington Park 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21412 Great Mill Road 20653 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Hems 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Deportment of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or then any Injury or other traumatic event, the Medical Examinat once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify. þ Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk-Charles Wesley Price ၉ ALICE UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Quade/son P.O. Box 88 West Glacier, MT 59936 20b. Place of Disposition (Name of cemetery, crematory or other place)
METRO CREMATORY INC. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ₩Other (Specify) in state 2/23/04 BALTO MD. 21. Signature of Funeral Service Sicensee Director SOCIETY of MD. INC. 22 Name and Address of Facility CREMATION 5 21201 299 FREDERICK ROAD BALTO, MD. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 2-3 d Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physicien: The law requires thet the death certificate be executed for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dus to (or as a consequence of) Division of Vital Records, P.O. Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Dld tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed by sign be t 24b. Were autopsy findings available prior to completion of cause of death? page 2 should 24a. Was an autopsy performed? certificate 1 Tes 1 Yes 2 Day completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 | Yes 2 | 1 | Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Matural 5 Pending e Hospital or Attending 124 hours after death. e Funerel Director: Aft 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) The Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Day, Year) D19917

State Registrar 30. Name and edds

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31. Date filed (Month, Day, Year)

BOYD

FEB 23

ess of person who completed cause of death (Item 23a) (Type, Print)

200

BAYSIDE CAFE CENTER at LEXINGTON PARK MD.

32. Registrary signature

State of Maryland / Department of Health and Mental Hygiene 2004 05576 Figure AMEND ITEM #25,27&28a-f PER ME G829 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year OI 2337 ONALD rebruary 02 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOPKIN Cin tos er 1 Year | If Under 24 Hrs. The John 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**⊠**M 2□F 290-05-3469 83 Director 1921 Jan 11, Indiana Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23s or 28s-f shov the Medical Examinational be notified at MD Carroll Westminster 1 ☐ Yes 21 No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1166 Long Valley Road 21158 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white Completed by 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) i Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 5+ minister/church administrator religion other permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important; If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dewey E. Rowe Gladys Cripe ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Rowe/spouse 1166 Long Valley Road Westminster, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronald S. Wade 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 mann or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (pras a consequence of): Examiner -4/1 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ope Due to (or as a consequence of): Examiner physician and the burial-transit death certificate be executed Due to (or as a consequence of): BY WENTER EXAMINER Physician/Medical as THE PROPERTY OF 2 IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by as been sig 1 ☐ Yes 2. ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page certificate 2 🗀 No of Vital 1 Yes 2 No 1 🗌 Yes Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 2 ER/Outpatient 3 DOA XX Yes 2⊟No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospital or Attending l ⊡flatural 5 Pending Injury 1/24/04 XX Accident investigation unk 1 ☐ Yes 2 ☐No subject fell 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1166 LONG VALLEY RD AT HOME within 24 hours a icai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 1.00 nd address of person who completed cause of death (Item 23a) (Type, Print) 600 N Ca 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 3 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 10 14
Amend Item 2 per DVR, G828, 02/23/04dbb ertificate of Death
Reg. No. 05577 2. Date of Death 01/26/2004 1. Decedent's Name (First, Middle, Last) 3. Time of Death J Month **Physician** P^{M} PEARL SOPHIA RICHARDSON 2330 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY ROCKVILLE MONTGOMERY HOSPICE - CASEY HOUSE 8. Date of Birth (Month, Day, Year) DEC 4 1914 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🕸 Days Hours Min. 212 38 5761 89 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes Ž ☐ No MARYLAND MONTGOMERY SILVER SPRING or 28a-f Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15311 BEAVER BROOK COURT 20906 U.S. or Itema 23a death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Peges 1 end 2 should be filed within 72 hours after onent of Health and Menta! Hygiene. ent of Health and Menta! Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced WHITE Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN WILLIAM HENDLEY ANNIE METZNER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 S. CRANBERRY SWAMP DRIVE, ANNA CROWE / NIECE FROSTBURG. MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State permit. Pege Department of Importent: If any injury or METROPOLITAN CREMATORY 1/27/04 ROCKVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 60 W. MAIN ST. SOWERS FUNERAL HOME, P.A. Parilou Jowers MD 21532 FROSTBURG, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC MELANOMA **Physician** YEARS resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760. as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy be detached for Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknows 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending within 24 hours after death.
To the Funerel Director: A completely filled in by the fu investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel (a) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) MARYLAND DYZYJZ ly FEBRUARY 23, 2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR . CHITRA RAJAGOPAL #347 PHILIP DRIVE PRINCE OLNEY MARY LAND 31. Date filed (Month, Day, Year) 32. Register's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 05578 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) EERUARY Day 9, 2004 6:15P **Physician** AROLD H. RIPPERGER /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Mar. 18, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Maryland 83 Director 219-01-8621 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28e-f show traumatic event, the Medical Exam or must be inclifted at 1 ☐ Yes 2 No Directo Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2719 Walder Drive Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. Y Yes 2 No I Yes, Give WW 11 Year or Dates: WW 11 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. Self-Employed yrs. Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry J. Ripperger, Sr. Marguerite Heller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is any injury or other traugonce. Eleanore P. Ripperger (Wife) 2719 Walder Drive Baltimore, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date XIX Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify) Immanuel Luth. Ch.Cem. 2-23-2004 Baltimore City, Md. 7401 Belair Rd. 21. Signature of Funeral Service Acens 22. Name and Address of Facility Lassahn Funeral Home Baltimore, Md. 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): END STAGE RENAL FAILURE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident investigation 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified mella M.O ,2004 mon D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON MARYLAND 21204 7601 JOGINDER F. MEHTA M. D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 3 2004

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05579 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEB/ 2004 12:57P M MARGARET T. ROBINSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City 6009 Eurith Avenue Baltimore City If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye May 15, 5. Social Security Number 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In yrs. last birthday) **Funeral** 1□M 21XF 1919 84 215-09-7052 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examples must be nutified at t)CYes 2 □ No Maryland Baltimore City Baltimore City Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 21206 6009 Eurith Avenue USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White þ 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore Board Elementary/Secondary (0-12) 12 yrs. other than College (1-4or 5+) of Education 3 yrs. Teacher perniit. Pages 1 and 2 should be flię Doportment of Health and Mental Hy Important: If Item 27 is marked other any njury or other traumatic event 900ct. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Nathaniel Travers Eugenia Talbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James B. Robinson, Sr. (Husband) 6009 Eurith Avenue Baltimore, Md. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 2-19-2004 Baltimore, Md. * 4 □ Donation 5 □ Other (Specify) 21. Si atur at Funeral Service ^{22. Name and Address of Facility}
Lassahn Funeral Home
7401 Belair Rd. Baltimore, part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** MCS /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examiner or Attending Physicien: The law requires that the death certificate be executed as the burial-transit and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medicai IF FEMALE: 23b. Was decedent pregnant use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death 23d. Date of delivery 2 Fetat death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year 5 Other (specify) 9 Unknown signed by d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 **X**No 3 Probably 4 Unknown 1 TYes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐ Yes 2 ☐ No 200No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 40m(Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director: /
completely filled in by the f 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and file of certifier 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) Charles St # 203, Balto, InD2/024 YHO 6565 MAO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oacks Registrar

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		1- State Unpend Ite Registrar	m#23a,27	Per ME	Fiftie 8 te 3 of 12	dealte g	R	leg. No.	0558
Physic	ian	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month		3. Time of Death
/Medi		Michael	D.	Reyr	nolds		Februar	y 19, 20	04 1:13 P
Exami	ner	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of	Death
		Franklin Square F 5. Social Security Number 6. S		e (In yrs. last birthday	Rosedale If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Baltimo	
Funeral Director			M 2□F	Vec	Months Days	Hours Min.	(Month, Day	(, Year)	Birthplace (State or Forei Country)
rector		Usual Residence of Decedent		12			5-30-9	1	Md.
MON		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limi
is de	to	Md. NA	n de la companya de l	Balt:	imore				X□Yes 2□N
28 not	irec	10e. Street and Number			10f. Zip Code		1	10g. Citizen of Wh.	at Country?
23a	ai [4262 Maple Path	Circle		2123	6		USA	
item 27 is marked other than "natural", or Itame 23s or 28e-f show other treumatic event, the Medical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spanic Alexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc.
or E	Y FL	1 Never Married 2 Married	1 ☐ Yes 2 🔀 N If Yes, Give		1 ☐ Yes 27 No	Specify:	,		
ural Ex	d by	3 Widowed 4 Divorced	Year or Dates:						Black
"nat	iete	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Giv	edent's Usual Occupa e kind of work done di DO NOT use retired)	uring most of work	ing	16b. Kind of Busin	ness/Industry
other than "vent, in Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)				Schoo	1
other ant, I	Ü	7th grade 17. Father's Name (First, Middle, Last)		51	udent	18. Mother's Name	e (First, Middle,		1
marked o	To Be	Michael	D.	Reynolds,	Sr.	Cara	М	ichelle	Huntley
T at	1	19a. Informant's Name/Relationship (1	Type, Print) Fath	19b. Mail	ing Address (Street a	nd Number or Rura	al Route Number	r. City or Town. Sta	ate. Zip Code)
27 is r	İ	Michael Devonne R	- Luci	·CL	2 Maple Pa				
Important: If item 2 any injury or other once.		20a. Method of Disposition			osition (Name of matory or other place			20c. Location - Cit	
y or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Md. Vet		" 2–24–	04	Croimari	Ilo Ma
inju		21. Signature of Funeral Service Licen			2. Name and Address		-	nore, Md.	lle, Md. 21202
any ir		#Eman	Vy =		March F.H.	East	1101 E	North A	_
aminer	iner	Sacuantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	a consequence of):					
physicisn and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequence of):					
he bu	edicai		d						
ing p		IF FEMALE:							
signed by the attending I be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date o Month	
deta	P P	Part II. Other significant conditions co	ontributing to death bu	it not resulting in the i	underlying cause giver	n in Part I.	23e. Did tot	pacco use contribu	ite to the cause of death?
sign d be	d by						1 🗆 Ye	s 2 □ No 3[□ Probably 4 NÜnknow
has been si je 2 should I	Completed						24a. Was a autops	y prio	re autopsy findings availab r to completion of cause o
pag	Ö						perform 1/2 Yes 2		in? Yes 2□ No
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hannital:			26. Place of Death	(Check only on	e)	
this ald	2		Hospital: 1 ☐ Inpatier	CANADA CONTRACTOR OF THE PARTY	e I	4 Nursing nor		ence 6 Other (Specify)
ctor: After y the funer	ion	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Work?		28d. Describe ho	ow injury occurred	
Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		iry - At home, farm, st . (Specify)		es 2 □No	28f. Location (St. City or Town	reet and Number on, State)	or Rural Route Number,
To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☑ Medical Exam	ysician: To the best o iner: On the basis of and manner star	examination and/or in	th occurred at the time exestigation, in my opi	e, date and place, a mion, death occurre	and due to the ca ed at the time, da	ause(s) and manne ate and place, and	er as stated.
Nithir To th comp	Me	29b. Signature and title of certifier			29c. License	number	2:	9d. Date signed (A	Month, Day, Year)
0		1 auto	_			_			
		30. Name and address of person who d	ompleted cause of de	eath (Itom 22a) (Tugo	O.C.M.	Eis	- $ -$	ebruary 2	20, 2004

State Registrar 31. Date filed (Month, Day, Year) 32. Registra FEB 2 3 2004

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201 oorkal

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:50 AM Month Yeer **Physician** , 2004 ROSEN **JOSEPH** Februrery /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore City Sinoi Hospital of Baltimore N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, AUG.11, Birthplece (State or Foreign Country) **Funeral** Months 10 M 2 F 83 MD 213-14-0069 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Madical Exercities count be notified at 1 ☐ Yes 2 ☐ No Funeral Director BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21215 U.S.A. 6711 PARK HEIGHTS AVENUE #114 or Itams 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Item any injury or other traumatic event, Ite Modified E-2000. Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates: Black. White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES FURNITURE RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROSEN BULK ALBERT IDA Rosen, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6711 PARK HEIGHTS AVENUE #114 - BALTIMORE, MD 21215 DEVERA ROSEN / WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State MOSES MONTEFIORE CEM. 2/20/2004 * 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Cancer Physician 41. /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate the first underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ţō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No 1 Yes 20 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funaral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 y. Burdaushaite February 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRADAUSKAITE Bulti more Mai 3 31. Date filed (Month, Day, Yes 2 State Registrar

ORIGINAL

3

Patient

State of Maryland / Department of Health and Mental Hygiene 2004 05582 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 405 PM **Physician** 2004 02 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Himore Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day, Year) Dec. 16,1942 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last 6. Sex **Funeral** Days Min 1 M 20XF 61 218-40-6905 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a State or Items 23a or 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or Items 23s or 28s-f show traumatic avent, its Medical Examinal mast be inclined at 1 Yes 2 No Baltimore County Maryland Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21236 4511 Fieldgreen Rd. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or Items 23, 1ry or other traumatic avent, It a Medical Examinan must by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes ※ XXNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 Yes XX No 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping-Own Home 12 yrs. N/A Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amelia H. Dull Benjamin F. Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Husband) 4511 Fieldgreen Rd. Baltimore, Md. 21236 Joseph M. Schlicht, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. Gardens of Faith Cem. 2-23-04 Baltimore, Md. 21. Signature of Funeral Service Lic ²²Lassahn Fuheral Home 7401 Belair Rd. Baltimore, Md. 21236 Approximate Interval Between Onset and Death Part . Enter the disease, or complication shock, or heart failure. List only one complications are complications. ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** lax /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Year Dav Month 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Monknown ed bluods 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 2 No 1□ Yes Division of Vital the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2. No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 27. Mann Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Baltimore MD Street 82. Registrar's Signatur 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004

			State of Maryland	Certificate of Death	Reg. No.	104 05583
1	Physic /Medi		1. Decedent's Name (First, Middle, Last) HARES W. TATE		2. Dete of Death Month Day	Year OH OHO
	Exami Funeral Director		4a Facility Neme (If hot institution, give street and number) BALTIMORE VA HUSP/TAL 5. Social Security Number 6. Sex. 7. Age (In yrs. last 144.16.1347 DM 2 F	birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min	ORE A	y of Deeth A 9. Birthplace (State or Foreign Country)
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Macilcal Examiner must be notified at	rector		BAITIMUNE	10g. Citizen of	10d. Inside City Limits 10d Yes 2 □ No What Country2
	er death with terms 23a of ner must be	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuben, Mexican, Puer	Specify Yes or No- to Rican, etc.) 14. Ra	ce - American Indian, ick, White, etc.
-0020	hours aft tural', or	by	1 Never Married 2 Married 1 Ves 2 No IV S Give Vear of Dates:	1 ☐ Yes 2 No Specify: 6e. Decedent's Usual Occupation	Speci	by: BLACK Business/Industry
21215-0020	ad within 72 glene. er than "na t, the Weste	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired) Ruck DRAVEY	rking	rspotsta.
Maryland	12 should be filed withir h and Mental Hygiene. ? Ie marked other than treumatic event, the M	To Be	17. Father's Name (First, Middle, Last) 6 lurge Ta Te	Ma.	me (First, Middle, Maiden Suma M , E	AM
Baltimore, Mar	es 1 and of Healt		Elizabeth TAIR,	96. Mailing Adress (Street and Number or Riverse) of Disposition (Name of Street, crematory or other place) RRMS TOPUST	BAUTO 1	n, State, Zip Code) WD 2 218 - City or Town, State ARY AWD
Balti	permit. Pag Department Important: if eny injury o		21. Signature of Funeral Service Licensee Willie Ellowell	22. Name and Address of Facility [] 4600 WBERRY	HALL BAN	neral Home
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Described in the control of the cause of the death. Described in the cause of the death. Described in the cause (Final disease or condition resulting in death) a	o not enter the mode of dying, such as dardian	c or Yespiratory arrest,	Approximate Interval Between Onset and Death
. 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medical Examiner	if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c	e consequence of): a consequence of):		
Вох	eath cer attendir I for use	cian/	d	- VI		
, P.O.	es that the deigned by the a	by Physician/	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.		ontribute to the cause of death? 3 ☐ Probably 4 월 Unknown
of Vital Records,	e law requires has been sig ge 2 should b	Completed b			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Tal H			25. Was case referred to medical	00 Diago of Da	1 ☐ Yes 25€No	1 ☐ Yes 2 ☐ No
of Vil	g Physician: er this certific teral director,	n: To Be	examiner? 1 Yes 2 No Hospital: 1 In Impatient 2 ER/ 27. Menner of Death 28a. Date of Injury 28b		ath <i>(Check only one)</i> dome 5 ☐ Residence 6 ☐ Oth 28d. Describe how injury occul	
Division	To the Hospital or Attending Physician: Within 24 hours after death. To the Funerei Director: After this certific completely filled in by the funeral director.	Certification:	1 ☑ Naturel 5 □ Pending (Month, Day Year) 2 □ Accident investigation 3 □ Suicide 6 □ Could not be determined 4 □ Homicide (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street and Numi City or Town, State)	ber or Rural Route Number,
	To the Hospital within 24 hours a To the Funerei C completely filled	edicai	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowled 2 ☐ Medical Examiner: On the basis of examination and manner steted.	end/or investigation, in my opinion, death occu	o, end due to the cause(s) and m rred at the time, date and place,	anner as stated. and due to the cause(s)
	Vith Tot	Σ	29b. Signature and title of certifier	29c. License number		d (Month, Day, Year)
	5		30. Neme end address of person who completed cause of death (Item 23e	P) 7643	2-19-20	04
*	Sta	ite	WSN-YEE TSA\ 2Z SOUTH GREEN E ST 31. Date filed (Month, Day, Year) 32. Registrar's Signature	· · · · · · · · · · · · · · · · · · ·	01	

State of Maryland / Department of Health and Mental Hygiene 2004 05584 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** .30 PM VICHAE EDRUALL 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 802 N. Rose Street Baltimore
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months 10 M 2□ F Director 219-76-3791 43 10-06-1960 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-1 show in than "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at No Yes 2 □ No Director Md N/a Baltimore10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 802 N. Rose Street 21205 death v Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Sever Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Laborer Construction Ith and Mental Hygir

27 Is marked other

r traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Claude R. Stewart 2 Cleo Floyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a Frank Stewart 5003 Arabia Avenue Baltimore, Maryland 21214 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1≅8urial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any injury or once. * 4 □ Donation 5 □ Other (Specify) 02-24-2004 Baltimore, Md Carmel 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityWise Funeral Services, P.A. Model WO 700 S. Beechfield Ave Baltimore, Md 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CANCER MING MONTH! /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 2 signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ IMMUNO DEFICIENCY 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has I autopsy perform 1 ☐ Yes 2 ZNo To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) မှ 1 Yes 2 No 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Injury 1 Natural 5 Pending death. investigation 1 □ Yes 2 □ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHY SICIAN D53590 FEBRUARY 20, 2004 0 624 NONTH BFOADWAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO ROOM 60 SYDNEY DY, 21205 BALTIMORE MO 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar FEB 2 3 2004

			For	State of Maryland			ental Hygiene	2001	05585
			State Registrar Qecepent's Name (First, Middle, Las.		Certificate of		Reg. No.	2004	3. Time of Death
>	Physici /Medic Examin	al	4a. Fecility Name (If not institution, give	William	S 4b. City, Town, o	For Location of Death	Month Day 'ebruary 20 4c.		6:30 P M
18°	LXamiii	C1	806 W. Lexington			imore		N/A	
9	Funeral Director		5. Social Security Number 216-92-0609 Usual Residence of Decedent	X M 2□ F 7. Age (In yrs. las.	t birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Year)	_ : Coun	ace (State or Foreign
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	th with the 23a or 28s	ai Director	10e. Street and Number SD6 . W . Ley	ungton ST	10f. Zip Code	1201	10g. Citiz	zen of What Coun	ins.
920	hours after death with the Maryland tural', or flema 23a or 28a-f ahow al Examiner natal be multified at	l by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spec an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - America Black, White, of Specify:	
Ų.	n 72	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	16b. Kir	nd of Business/Ind	ustry
	Hyg The	Be Co	17. Father's Name (First, Middle, Last)		VVa V CI	18. Mother's Name (First, Middle, Maiden	Sumame)	UI NA
Maryland		To E	K0590 W.	lliams		Loyce	V V / I I I - I - I	ms	
Mai	12 s h ar 7 is trau		Journal's Name Relationship (7)) NAOH. 8	19b. Mailing Address (Street	am Dra.	Ave Sumber; Sity of	CUTO .	NO.
Baltimore,			20a. Melpod of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	ee of Disposition (Name of etery, crematory or other pla	(e) 2 2	20c. Lo	A Py	wn, State
Balt	permit. Pages Department of the Important: If its any injury or of once.		21. Signature of Funeral Service Licens	Howell &	22. Name and Addre	oss of Facility 46	01 Liber 212-04	(Howe	Funene)
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the deeth. In cause on each line.	Do not enter the mode of dy	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. HANG I WG Due to (or as a consequent	nce of):				
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b	nce of):				
	nd nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.					
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ord	w requir been si should I						1 Yes 2	No 3 ☐ Proba	bly 4 Unknown
	The larate has	Completed					24a. Was an autopsy performed? 1 Yes 2 Y No	prior to con death?	sy findings available pletion of cause of
Vital	Physician: this certifical	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatient 3□ DOA Oth	26. Place of Death (Check only one) 5 ☐ Residence 6	X	at scene
of		\vdash	27. Manner of Death		Bb. Time of 28c. Injury Wo	y at 28	d. Describe how injury	occurred	
Division	Attending r death. ector: After by the fune	catlo	1 □ Natural 5 □ Pending 2 □ Accident investigation 3 ☑ Suicide 6 □ Could not be	tain 2-20. 04	4:30 PM 10	Yes 2 TNo S	att recein		
-	- 0 -	Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, tarm, street, factory, office		City or Town, State)		Poute Number,
4	To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, death occurred at the til n and/or investigation, in my o				
		Me	29b. Signature and title of certifier	eishel	29c. Licens	O.C.M.E.		signed (Month, Clary 21,	
	9		30. Name and address of person who c	ompleted cause of death (Item 23		treet, Balt	rimore Mar	rvland 2	1201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		/	Lancie / Fide	LJIMA Z.	LEVI
DU	Registr		FEB 2 3 200	Dave 1	is promos				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 4 05586 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** WHITAKER 10-30P-M BEATRICE FEB 2004 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth Min. Month, Day ea ultimore e 5. Social Security Number 9. Birthplace (State or Foreign Country)

Outh Caroline 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 205-20-573 (Usuel Residence of Decedent 1□M 2XF Yrs. Director Carolina Pegas 1 end 2 should be filed within 72 hours after deeth with the Marylend nart of Health end Mental Hygiene. nt: if Item 27 is marked other than "naturei", or items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No. Maryland Funeral Director Mor 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Be Completed by Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ P111 1 aa lamie ra 19a. Informant's N me/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mem. Par 1200 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Liounsee 22. Name and Address of Fecility Joseph 22221 Hor ra North e of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical DEMENTIA monitos Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attanding Physician: The lew requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown edicai Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 DNO 1_Yes 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 16 3□ DOA 2 ER/Outpatient 28c. Injury at Work? To the Hospital or Attanding Ph within 24 hours aftar death. To the Funeral Diractor: After thi completaly fillad in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 □Naturel 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 53150 FEB ZOTA 2004 uple MD 7 BALTIMONE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10W50N 400 Ru 11) 21204 SHAKUNMACA CUPTA 31. Date filed (Month, Day, Yeer) 32. Registrer's Signaty

DHMH 16 Rev 6/95

State

Registrar

FEB 2 3 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05587 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** and 7:15AM 200 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner n/a TMON If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Age (In vrs. last birthday) Under 1 Year Birthplace (State or Foreign Country) **Funeral** 64 Aug. Maryland Director Usuel Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits *how in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Md. Anne Arundel Co. Glen Burnie Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21061 51 Bremer Drive death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Warehousing Supervisor n Is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Wagner Sr. and Mental Α. Jay Ellen Baier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is (Son) 1116 Armstead Street, Glen Burnie, Md. 21061 Willard H. Wagner Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Cedar Hill Cemetery 02/21/04 Baltimore, Md. injury 22. Name and Address of Facility Polyniak Funeral Home P.A 21. Signature of Funeral Service Licensee Kevin E. Ecker PD. 237 E. Patapsco Ave. Baltimore, Md. 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Day ō Month 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed Deed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 1 Yes 2 No 1 Yes completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2) No 2 ER/Outpatient 3 DOA Certification: To 1 Tes this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) or A To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ompleted cause of death (Item 23a) (Type, Print), SUMS, Dept krnaf Medicine -Wasu ms 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar		State of Ma	aryland /	Cer	tificate of	Death		gien Reg. N) Lį	05588
	Physicia	an	1. Decedent's Name Meta Dea		st)					2. Date of De Month Februa	ath D	16, 2	eer 0 0 4	3. Time of Death 7:3() p M
	/Medic Examin	al			e street and number)			4b. City, Town, o	r Location of Death			c. County of		7.30 5
		•		ss Hospi		·			Silver S			Montgo	-	
	Funeral Director		5. Social Security Nu 219-46-7	478 1	ex 7. Ag	e (In yrs. last	birthday) 8 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da Feb 18	th y, Yea }, 1	945	. Birthpl Count DC	ace (State or Foreign try)
	/land		Usuel Residence of I	10b. County		10c. City, To	own or Lo	cation					10	Od. Inside City Limits
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	with the	Director	10e. Street and Num		Dawlerrary			10f. Zip Code 20895				Citizen of Wha		•
	leath v	erai	9910 Ken	sington.	12. Was Decedent	Ever in U.S.	13. \		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		14. Race -	America	an Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than *naturel', or items 23e or 28e-f show any injury or other traumatic event. The Madical Exertifier must be notified at angle.	by Funerai	1 Never Marrie	. —	Armed Forces? 1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:			f Yes, specify Cubi 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)		Specify:	White, e	
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4			23a. Part1. Enter the shock, or hear	e disease, or com t failure. List only	plications that caused one cause on each li	the death. D	o not ent							Approximate Interval Between
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٥.	res that igned by be deta	by Pr	Part II. Other signifi	cant conditions	contributing to death b	ut not resultin	g in the u	nderlying cause giv	en in Part I.				ite to th	e cause of death?
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Division of Vital Records,	cate has	Completed								auto	psy rmed?	prio dea	r to con th?	appletion of cause of
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οl	ig Phy ter this neral d	n: To	27. Manner of Death	1	28a. Date of Inju (Month, Da		b. Time of	-	y at	28d. Describe			ороспу	/
sior	Attending or death. ector: After by the fune	catic	1 ☑Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending investigation 6 Could not be	on .			M 1	Yes 2 □ No					
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	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)		hysician: To the best miner: On the basis o and manner st	f examination								
	To the To the compl	Me	29b. Signature and	title of certifier				29c. Licens	e number		29d. D	ate signed (A	Month, E	Day, Year)
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Joan Haskins 04-01194 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Marylai	nd / Depa <i>Cei</i>	artment of H	lealth an Death	d Mental Hy	giene Beg. No	20	04	05	589
	Dhoofa		Decedent's Name (First, Middle, L. To one		A -1-				2. Date of Dea	ath		· · · · ·	3. Time	of Death
	Physici /Medi		Joan	Marie	Ask	Ins			Februa	ry 1	· _	Year 004	9:15	A M
	Examir	er	4e. Fecility Name (If not institution, g		nber)		4b. City, Town, o	r Location of D	eath	4c.	County o	f Death		
	<u> </u>		630 Gutman Avenu		- 4		Balti				N/A		,	
	Funeral Director	ŷ	21660-7977	Sex 1 □ M 2 2 □ F	7. Age (In yrs. 51	Yrs.	If Under 1 Year Months Days	Hours N	Hrs. 8. Date of Birth	3 Year)	L952	9. Birthpl Mally	ace (State Yand	or Forei g n
	pus *		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or Lo	ecation			_		1/	34 1	22.11.2
	Maryla	tor	Virginia Warı	en		entonvi						10	0d. Inside (1 🗌 Ye:	s 2 No
	with the 3s or 28	Il Director	10e. Street and Number 526 Catron R	idge Roa	d		10f. Zip Code	22	2610	10g. Cit	izen of Wh	nat Count	-	
36	should be lied within 72 hours after death with the Maryland and Mental Hygiene. The state of the than "natural", or liems 23s or 28s-f show marked other than "natural", or liems 23s or 28s-f show matic event, the Medical Examera must be multipled at	y Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Dece Armed For 1 Tes If Yes, Give	ces? 2 XNo	1	Was Decedent of H 1 Yes, specify Cubi 1 □ Yes 2 ☒ No	dispanic Origin? an, Mexican, Pu Specify:	? (Specify Yes or No- uerto Rican, etc.)		14. Race Black, Specify:	White, e		
00-0	72 hour natural	ted b	3 Widowed 4 Divorced 15. Decedent's I (Specify only highest g	Year or Da	ites:	16a. Deced	dent's Usual Occup	pation		16b. Ki	nd of Busi			
1212	within iene. r than "	Be Completed by	Elementary/Secondary (0-12)	College (1-	-4or 5+)	life. I	kind of work done DO NOT use retired TGC WOLKS	d)	working					
Maryland 21215-0036	ould be tiled Mental Hygi arked other atic event, I		17. Father's Name (First, Middle, Las Arthur W. As				02 ,,021,0	18. Mother's h	Name (First, Middle, Velma	Maiden Irer	,		risto	20
lary	d 2 should th and Men 7 Is marke treumatic	ဥ	19a. Informant's Name/Relationship Arthur W. Aski	(Type, Print)	20	19b. Mailir	g Address (Street		Rural Route Number					
	an ealt m 2		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name of	T	Date	20c Lo	cation - Ci	iby or Toy	un Stata	-
Bartimore,	permit. Pages 1 Department of H Important: If ite any injury or ott once.		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec	ity)	state Sr				b. 16, 200)4	Smit	nsbu:	rg, M	arylaı
na	Depar Import		21. Sign fure of Funeral Service Lice 23a. Part 1. Enter the disease, or con- shock or heart failure. List only	Busto	1000°	21 K	Name and Addre	d Basfo	rd Funeral	L Ho	me			
ş Ş Se	Physician /Medical Examiner physician and physician and the portal-transit the portal-transit	dicai Examiner	shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a	or as a consector as	QUIHO. quence of):					-		fnterval Be Onset and	rween
DOX O	inat the death certification by the attending phy detached for use as the	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 Yes 27 No 9 Unknown		th 2 ☐ Feta int at time of d	il death 3 🗌	Ectopic pregnancy Other (specify)			2	3d. Date of Month		•	Year
ν, T	60	by P	Part II. Other significant conditions	contributing to dea	ath but not res	ulting in the un	derlying cause givi	en in Part I.	23e. Did tot					-
Record	0 70	jeted			· · · · · · · · · · · · · · · · · · ·				1 ☐ Ye	es 2[Probai	sy findings	Jnknown
	ate h	e Completed	25. Was case referred to medical						autops perform 17 Yes 2	y ned? ≧□ No	prio	r to com µth?	pletion of c	ause of
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	er this	L'u	27. Manyer of Death	28a. Date of	Injury	28b. Time of	28c. Injun	1	28d. Describe ho			(Бресіту)	at sc	ene
VISION	death. ctor: After y the funer	atio	1 Natural 5 ☐ Pending investigation		, Day Yeer)	Injury		<br Yes 2 □ No					•	
7	after de Directo	Certification;	3 ☐ Suicide 6 ☐ Could not to determined	280. Place o	of Injury - At ho g, etc. <i>(Specif</i>	ome, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and , State)	Number	or Rural I	Route Num	ber,
To the Moonitel	within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the t miner: On the bas and manne	sis of examina	wtedge, death tion and/or inv	occurred at the timestigation, in my op	ne, date and pla pinion, death oc	ice, and due to the ca courred at the time, da	iuse(s) ate and	and manne place, and	er as stat I due to ti	ed. he cause(s)
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			30. Name and address of berson who	completed cause	or death (Item		*	eet, Ba	ltimore, I	Mary	land	212	01	
	Sta Registra	7.6	31. Date filed (Month, Day, Year)	2004 D	gistrar's Signa	ture	front st							

State of Maryland / Department of Health and Mental Hygiene a o o

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Physician (Modical Examiner) Application Consequence of Consequence			23a. Pert1. Enter the disease, or comp	olications that caused the d	leeth. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory arr	est,	App	roximate
Part II. Other significant conditions contribute to the cause of death Diabetes Mellitus	/Medic Examin	al er e	disease or condition resulting in death)	Due to Du	o (or as a consec ze Hear	quence of): t Failu		Diseas	е		
Diabetes Mellitus Coronary Artery Disease 1 1 1 1 1 1 1 1 1	tath certificate be exe attending physician at for use as the burial-i	~	resulting in death) Last		o (or as a consec	quence of):					
The serious of the se	daat na att ed fo	sicia	Part II. Other significant conditions co	entributing to death but not	resulting in the u	nderlying cause giv	ren in Part I.	23b. Did to	bacco use co	ntribute to the	cause of death?
25. Was case referred to medical examiner? 1	that tha ned by the edatache	y Phy	Diabetes Mel	litus				1□ Y	es 2 No	3 ☐ Probably	4 Unknown
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) William DuBoyce, MD 4000 Mitchellville Rd. B216 Bowie, Md. 20716 31. Dete filled (Month, Day, Year) 32. Signature	lor Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be e	pieted t	Coronary Arte	ery Disease	9			24a. Wes a	n autopsy ned?	available	le prior to tion of cause
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) William DuBoyce, MD 4000 Mitchellville Rd. B216 Bowie, Md. 20716 31. Dete filled (Month, Day, Year) 32. Signature	The ita ha	E						40 Y	s 22No	1 □ Yes	s 20 No
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30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) William DuBoyce, MD 4000 Mitchellville Rd. B216 Bowie, Md. 20716 State 31. Dete filed (Month, Day, Year) 32. Signature	al or Att saftar de I Direct od in by	Sertific	dotorminod	286. Piece of injury - A	t home, farm, str ecify)	eet, factory, office				er or Rural Rou	ite Number,
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							Rd. B2	l6 Bowi	e, Md.	20716	5
		State		32. Sgistrer's Si		141					

State of Maryland / Department of Health and Mental Hygiene 2004 05591 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3:45P M **Physician** Pebruary Brown 1, 2004 Robert Lester /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Lanham Doctors Community Hospital 8. Date of Birth (Month, Day, January 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 6,1923 Indiana 1 M 2□ F Months 317-18-0245 81 Director Usuel Residence of Decedent 10c. City. Town or Location 10d. fnside City Limits 10a State 10b. County 28e-f show event, the Medical Examiner rount be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itame 23a or 9515 20706 Sheridan U.S.A. Street Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1. □Yes 2 □ No IFYes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married White Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WWII Year or Dates: "netural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) Coflege (1-4or 5+) FDIC Systems Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 is marked oth any liqury or other traumatic event 2008. Be Bushrod Brown Maggie Hemminger Lester 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9515 Sheridan Street, Betty Brown/ Wife Lanham, Maryland 20706 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition voi Piace of Disposition (Name or cometery, crematory or other place)
Maryland Veterans
Cemetery 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/5/2004 Crownsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Euroral Service Liven 16000 Annapolis Road, Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician RENA FAMURE 1-CJTE /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last INFARCTION Examiner or Attanding Physician: The law requires that the death certificate be executed BILLTERITE Price Unchild and burial-tran Due to (or as a consequence of) Box 68760. attending physicien Physician/Medicai e L IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ Division of Vital Records, pe Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed PULMEDUME CESTRUCTY 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an BERLAHERYE MOLE BING certificate has autopsy 2 X No 1 Yes ERCBROWSCU 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident fnjury 5 Pending s after de-1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 TSuicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dev. Year) 0 412 D55559 FETOEL HEL 2004 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 7525 SPLINE SOTLES GREEK BURT THOMAS 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State 3 FEB 0 Registrar

Physician / Medical Examiner 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sepsis Syndrome Sequentially list conditions, if any, leading to immediate cause or initiated events resulting in death) Last Due to (or as a consequence of): Aspiration Pneumonia Due to (or as a consequence of): Cause (Disease or inpury that initiated events resulting in death) Last Due to (or as a consequence of): Cusus (Disease or inpury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.				1 - State of Maryl Registrar	and / D	epar Cert	tment of H ificate of I	lealth Deat	and Me h	ental Hygi Re	ene 200	+ 05592
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Provided to the composition of t	Ba	perm Depa Impo any i		21. Signature of Purieral Service Licensee								
Proyection Medical Examinor Sequential isolate or condition and address or injury and address or property of the standard property of the standar				23a. Part1. Enter the disease, or complications that caused the	death. Do no	_						Approximate
Due to (or as a consequence of): Aspiration Pneumonia If style, leading to immediate Sequentially list conditions If sequentially list conditions If sequentially list conditions If sequentially list conditions If sequential list conditions If sequential list conditions If sequential list conditions	Ŀ	Pnysician		Immediate Cause (Final Congris Car	ndrome	e						Onset and Death
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Cause (Desiration of the part		Examine	<u>.</u>	Sequentially list conditions, b			ia					
The contribution of the completion of the comp		ted	nlne	Cause (Disease or injury	isequence o	n <i>):</i>						
The contribution of the completion of the comp	,	execu n and ial-tra	Exar	that initiated events c.	sequence of	if):	•					
FFEMALE 23d. Date of delivery 23d. Date of deliv	9	ite be iysicia ne bur		d						_		
End Stage Renal Disease, Diabetes Mellitus, Status Post Cerebrovascular Accidect, 24a. Was an autopsy performed of cause of per	9	artifica ling ph e as th	Med	IF FEMALE:								
End Stage Renal Disease, Diabetes Mellitus, Status Post Cerebrovascular Accidect, 24a. Was an autopsy performed of cause of per	6 2	attend for us	ian/	in the past 12 months?	Fetal death							
End Stage Renal Disease, Diabetes Mellitus, Composition of the completion of cause of the cause of the completion of cause of the cause of the cause of t	o.	the de	yslc	1 Yes 2 No	or death	2	iner (specify)					
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				DIL HMANNSUNDA			D533	67]	February	5, 2004
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	277				-		6.4.					

			For State Registrar	State of Marylan	d / Depa	artment of H	lealth and Death		giene 20 (04 05593
	Physicia	an	Decedent's Name (First, Middle, Last) Guy C. Barron				· · · ·	2. Date of Dea Month Februar	Day Y	3. Time of Death 6:05 A ^M
	/Medic		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Deat		4c. County of	
	Examin	er	Chesapeake Hospice			Linthic			Anne A	rundel
604	Funeral Director		Social Security Number 6. Sex		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h y, Year) 1927	Birthplace (State or Foreign Country) Georgia
	p >==		Usual Residence of Decedent 10a. State 10b. County	10c Cib	y, Town or Lo	neation				10d. Inside City Limits
	Manyla f shov	ō	MD Anne Arur		Annap					1 ∑ Yes 2 ☐ No
	28a-	rect	10e. Street and Number		типар	10f. Zip Code			10g. Citizen of Wh	at Country?
	3a or		2677 Compass Drive	2		21	401		USA	
	ms 2	hera		12. Was Decedent Ever in U.	S. 13.	Was Decedent of H		Specify Yes or No-		American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show appring yor other traumatic avent, The Medical Exam. at Intel to Indiffed at angles.	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 □Yes 2 □ No If Yes, Give 1945		If Yes, specify Cubi	Specify:	to Rican, etc.)	Specify:	White, etc. White
ö	urat	d b	3 ☐ Widowed 4 🛣 Divorced		46	dent's Usual Occup	ation	1	16b, Kind of Busin	acce/leductor
21215-0036	"nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	during most of wo	rking	160, Kind of Busin	10SS/Industry
12	withi	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	NSA	Internal	Analyst		Departmen	nt of Defense
0	Hyg Hyg other	Be C	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
Maryland	should be and Mental I marked o umatic ave	To B	Guy C. Barron				LaTre	elle Dool	ittle	
ary	shot and N	_	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Maili	ng Address (Street	and Number or R	ural Route Numbe	r, City or Town, Sta	ate, Zip Code)
	and 2 Balth a n 27 ls		Daniel Barron/ So			2 Bristol	Ct. Ch		Beach, 1	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	emetery, crei	sition (Name of matory or other plac		Date	20c. Location - Ci	
Baltimore,	Pages tment of I tant: If It tjury or o		`4 □ Donation 5 □ Other (Specify)	Hur		ematory	7 E 10	//2004	Waldorf	
Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Fureral Service License		11	2. Name and Addre	I.C	bert E. Road Bow	Evans Fur ie, MD	neral Home 20715
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deathe cause on each line. Due to (or as a consequence)	Car	ACCV	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death 3.25 years
- T	III M.	iner	Sequentially list conditions, if any, I saumy to immediate cause. Enter Underlying	Due to (or as a consequ	uerice of):					
,092	ate be executed hysician and the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
687	phys the	-		J						
.O. Box (The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of de	I death 3	Ectopic pregnancy Other (specify)	/		23d. Date of Month	
<u>a</u>	that the	Ph	Part II. Other significant conditions con	ntributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?
ds,	signe signe	d by	·	· ·		, ,		150	es 2 □ No 3	☐ Probably 4 ☐ Unknown
202	v requir been s should	lete						24a. Was	an 24b. We	re autopsy findings available
Vital Records,	ysician: The lav is certificate has director, page 2	Completed						autop perfo	sy prio med? dea	r to completion of cause of
/ita	iiclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		ot 3 DOA Oth	or	ath (Check only o		
of	Physician: r this certifica ral director, I	10	1 Yes 2 No	1 Inpatient 2	ER/Outpatier 28b. Time o	" 3LI DON	4 Nuising i	7	lence 6 D other now injury occurred	
On	fune fune	tion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	Injury	Wor	rk? Yes 2 □ No	200. 2030100 1	ow injury occurred	
Division	or Attending Ifter death. Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st		-	28f. Location (S City or Tow		or Rural Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical Ce	29a Certifier Certifying Phys (Check only 2 Medical Exemir	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the time to the time of time of time of the time of	me, date and plac pinion, death occ	e, and due to the ourred at the time, o	cause(s) and mann date and place, and	er as stated. If due to the cause(s)
	othe omple	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (/	Month, Dey, Year)
	⊢ s ⊢ ö		* fienere l	very, mr.	2	DS	2830		Februar.	17,2004
			30. Name and address of person who co	empleted cause of death (Item	123a) (Type,	Print) Read #2	soo An	raplis	MO	21401
-5%	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 9 2	32. Registrar's Signa	ture	book)	1/-			Month, Dey, Year) 17,2004 21401

State of Maryland / Department of Health and Mental Hygiene 2 05594 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Feb. Braglio 2004 2:15 A.M Joseph 6 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mariner Health Care Center Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth (Month, Day, Year) | Sept. 16 1911 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 217-22-9071 92 Yrs. Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Woodstock Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 3026 Hernwood Road 21163 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ፩ 3 ⅓Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Bar & Restaurant 8th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any liquy or other treumatic event, sings injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Braglio Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anthony Braglio, Sr. Grandson 3014 Hernwood Road Woodstock, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 9 2004 Granite, Maryland Granite Church Cem. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Directors, PA 1212 W. Old Liberty Road Winfield, MD amus. 21784 23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a ch line. Approximate Interval Between Onset and Death mmediate Cause (Final discase or condition resulting in death) **Physician** ARTERY DISEASE . CORONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: attending physicien and for use as the burial-transit Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetel death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 Dunknown CANCER 1 ☐ Yes 2 ☐ No Completed PNEUMONIA. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? res 2 page MYSPHAGIA. OROPHARTNGEAL certificate 1 ☐ Yes 25. Was case referred to medical examiner?

1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) 26. Place of Death (Check only one) director, Other: 4 Jursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ပ 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) PHYSICIAN D42723 FEBRUARY 2004 MS an (30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHWEST HOSPITAL 10 HARISH. AVVERAHALLI M 5401 COURT ROAD.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB 0 9

2004

Division of Vital Records, P.O. Box 68760,

A Sparke

32. Regigrar's Signature

OLD

State of Maryland / Department of Health and Mental Hygiene 2004 05595 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dorothy Brooks January 30 2004 6:40P Virginia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 750 Eagles Court Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Apr. 10, 1922 9. Birthplece (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 X □ F 81 218-05-3722 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County in then "natural", or items 23a or 28a-f ahow the Medical Evantimer must be notified at 1⊠Yes 2□No Westminster Maryland Carroll Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21158 750 Eagles Court U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 DNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) completed) Elementary/Secondary (0-12) College (1-4or 5+) state hospital nurse 12 other permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked otherny injury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unknown) Annie Fossett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert S. Brooks/husband 750 Eagles Court, Apt. 2D Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Joy Cemetery 2/3/2004 Uniontown, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenset Hartzler Funeral Home atharine E. Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an elach line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months
1 ☐ Yes 2 ☑ No Month Day Year detached for 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 ☐ Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 Yes 2 No 2 No 1 🗆 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To his funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year, 29c. License number 29b. Signature title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mita PIVIO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 2004 5 Registrar

DAP	1 - State Unpend Item/F18 25ate of Maryland / Linpend Item/F23a, 27, Per ME, G828, 3/4	Department of Health and No. 100 Dearth	Mental Hygiene 2004	05596
*	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Physician /Medical	Douglas Marshall Bircher	Jr.	FEBUARY 1,2004	7:05p M
Examiner	4a. Facility Name (If not institution, give street and number) GARRETT COUNTY HOSPITAL	4b. City, Town, or Location of Death OAKLAND	4c. County of Death	
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 33	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birth Cot	place (State or Foreign intry) V
pu *	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits
Maryling sho	WV Mineral Elk	Garden		1⊠Yes 2□No
in the Mac or 28s-f st be coulled	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	intry?
23a c	PO Box 105	26717	USA	
of the death of the country of the c	11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Black, White	
J36 Jrs aft Ji, or		1 ☐ Yes 2X No Specify:	Specify: Wh:	ite
5-00		Sa. Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business/l	
21215-00 ed within 72 hou ygiene. Per than "natura is the Wedical E. Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	Stone& Rock	ς
d 2 Hilled v Hygie Int. In	11 17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Sumame)	
Vland vuid be fil Mentat H arked out attic even	7 12 1 1a 1	Sylvia	Bolyard	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural", or iteme 23s or 28s-f show sny injury or other traumatic event, the Medical Examiner must be mutified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Ru		ip Code)
and 2 ealth The Table	Douglas M. Bircher	PO Box 105 Elk Garde	turium a	Tarrier Charles
Baltimore, semil. Pages 1 ar page	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	of Disposition (Name of terry, crematory or other place)		
Itim ii. Pa iitmen iitmen ortant:	*4 □Donation 5 □Other (Specify) Kalba	augh Cemetery [Feb :	5, 2004 Elk Garden	VVV
Ball permi Depari Importi sny ir	Manual & Bundeck	David A. Burdock F	H itzmiller, MD 2151	38
·	23a. Part. Enter the disease, or complications that caused the death. E shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician	Immediate Cause (Final disease or condition Arteriosclerotic	Cardiovascular Disease		Onset and Death
/Medical Examiner	resulting in death) Due to (or as a consequence)	pe of):		
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68760, cate be executed physician and the burial-transit docate Examin.	d			
S, P.O. Box 6: es that the death certific gned by the attending p be detached for use as by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant	-	23d. Date of deli	л егу
Box death cert death cert attending of for use a circlar/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No		Month	Day Year
P.O. B. that the deatt the deatt detached for detached for Physicia	9 Unknown	- (- About a de la la companya de De Al	23e. Did tobacco use contribute to	the source of death?
Division of Vital Records, F or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be de ertification: To Be Completed by P		g in the underlying cause given in Part i.		bably 4 Unknown
il Record The law requir cate has been s page 2 should			autopsy prior to c	opsy findings available ompletion of cause of
The The page			performed? death? Yes 2□No Yes	2 No
f Vital F ysician: Th is certificate director, pag	25. Was case referred to medical examiner?	Other	th (Check only one)	
n of \ g Physi er this c seral dire	XX es 2 No 1 Inpatient 2Lack	b. Time of 28c. Injury at	ome 5 Residence 6 Other (Special 28d. Describe how injury occurred	ity)
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pours baral filler		dge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	, and due to the cause(s) and manner as rred at the time, date and place, and due	stated. to the cause(s)
To the Hos within 24 hu To the Fun completely		29c. License number	29d. Date signed (Month	
	() tokemo	OCME	FEBUARY 2,2	004
3	30. Name and address of person who completed cause of death (Item 23	111 Penn Street,	Baltimore, Marylan	d 21201
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1. 10		
Registrar		Locale J		

### Specific Country Specific	Emerson Joseph Bennett 4. Facility Name (Froz. Marchano) societ and running 4. Facility Name (Froz. Marchano) societ and running 4. Facility Name (Froz. Marchano) 4. Facility Name (Froz. Marchano) 5. Sach Security Name 5. Sach Security Name 5. Sach Security Name 6. Sach Security Name 7. Age of year. Sach Security Name 7. Age of year. Sach Security Name 8. Sach Security Name 8. Sach Security Name 10. Sach Secu		For State of Maryland / Department of He 1 - Registrer Certificate of D	eaith and ivideath	Reg	ene 200 L	
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Comment Comm	Cambridge Committee Comm		Mary B. Gallagher Daughter PO Box 194, Hi	llsboro,	Marylan	d 21641	
The composition of the control of	South Second Street Denton, Maryland 2162		1 ☐ Burial 25 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place))	_		
23a. Part I. Enter the difficase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only not cause on each line. Immediate Cause (Final disease or conditions) Security in death of the conditions. I arry, tasking to immediate devents rule. Due to (or as a consequence of):	230. Date of delivery months of specific death of the specific delivery months of the specific death of the sp				P.A. eet. Den	ton. Marv	land 21629
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FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day Year 1 1 Yes 2 No 3 Probably 4 Qurking 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Qurking 25b. Was case referred to medical examiner? 1 Yes 2 No No Hospital: Impatient 2 ERVoutpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27b. Mayner of Death Injury 28b. Date of Injury 28b. Time of Injury 28b. Date of Injury 28b. Time of Injury 28b. Date of Injury 28b. Time of	ical Exami	that initiated events C.				
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	Labelmi Vaielyanathan MD DOSS 749 FEBRUARY 5 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opin	e, date and place, inion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as e and place, and du	s stated. e to the cause(s)
Marshim Vanelyanathan MD 1055 749 FEBRUARY 5 2004	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Σ	29b. Signature and title of certifier 29c. License r	number			,
			Islahm Varelyanathan MD DOS	5-74	49 FG	EBRUARY	5 2004
	31. Date filed (Month, Day, Year) 32. Registrar's Signature		Lakshmi Vaidyanathan, M.D., 219 South Washingt	ton Stree	et, Easto	n, Maryla	nd 21601

Bennett, Emerson

Louis C. Brady 04-01176 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Maryland /	Department of Health and Certificate of Death	Mental Hygier	e 2004 05598
	Physici /Medic	an	1. Decedent's Name (First, Middle, Last) LOUIS CleMIT	t Brady		2. Date of Death Month E	3. Time of Death 12, 2004 12:33 P
*	Examin Funeral	er	4a. Facility Name (If not institution, give s 401 West Main S 5. Social Security Number 6. Sex		4b. City, Town, or Location of Dea Emmitsburg irthday) If Under 1 Year If Under 24 Hr Yrs. Months Days Hours Mir	s. 8. Date of Birth	Frederick 9 Birthplace (State or Foreign Country)
	Director story ō	Usual Residence of Decedent 10a. State 10b. County Frederic		wn or Location	17000. [4]	1961 Bridge tong NJ 10d. Inside City Limits 10 Yes 2 No	
	h with the h 23a or 28s-	al Director	10e. Street and Number 401 W. Main	Street	10f. Zip Code 2172		Citizen of What Country?
980	72 hours after deeth with the Maryland naturel', or Items 23a or 28s-f show littel Experience must be natified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? Yes 2 No Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 📈 No Specify:	Specify Yes or No- no Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within lene. than	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 16a completed) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking 16b.	Kind of Business/Industry Food
Maryland 2	be filed htal Hyg od othe svent,	To Be Co	17. Father's Name (First, Middle, Last) Larry Wea		18. Mother's No.		rison
	1 and 2 Health a sm 27 is ther trai		19a. Informant's Name/Relationship (Ty) Deloces Morriso 20a. Method of Disposition	n (Mother)	b. Mailing Address (Street and Number or F 198 South Hig of Disposition (Name of ery, crematory or other place)	h St. Ho	y or Town, State, Zip Code) Mover, PA (733) Location - City or Town, State
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	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death. Do e cause on each line.	o not enter the mode of dying, such as cardi		Approximate Interval Between Onset and Death
68760	Medical Examiner be executed by sician and brial-transit sthe prival-transit	edical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence Chronic Due to (or as a consequence	st The liver		
O. Box 68	ne death certif the attending hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dear 4 □ Pregnant at time of death 9 □ Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
ecords, P.	 requires that it been signed by should be detac 	by	Part II. Other significant conditions cor	tributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Munknown
α	The ate h	Completed				24a. Was an autopsy performed	
ion of Vital	ding Phys h. After this funeral di	Certification: To Be	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Outpatient 3 DOA Other: 4 Nursing Time of Injury M 1 Yes 2 No	eath (Check only one) Home 5 Residence 28d. Describe how in	ijury occurred
Division		I Certifle	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)		City or Town, St	
	To the Hospitel or within 24 hours after To the Funeral Direction completely filled in	Medical			ge, death occurred at the time, date and pla and/or investigation, in my opinion, death oc 29c. License number	curred at the time, date a	
•	- A		30. Name and address of person who co	1 / 12			ebruary 13, 2004
	St Regist	ate	31. Date filed (Month, Day, Year) FFR 2.3 201	32, Registrar's Signature	111 Penn Street	et, Baltimon	ce, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:49 P M January 25, Russell D. Corbin 2004 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan . 25, 1922 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 ☐ F 231-12-9444 82 Virginia Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-1 show and injury or other traumatic event, the Medical Examiner must be neutified at 2008. 1 Yes 2 No Maryland Anne Arundel Lothian Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 113 E Street 20711 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: W.W. I 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Maryland 21215-0036 þ 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Painter Home Improvement 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles Lee Corbin Mary Ella Kirkpatrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Terry L. Nebel/Niece 516 Kingdom Court, Odenton, Maryland 21113 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 1-29-04 Edgewater, Maryland 21. Signatur 1 F legal rvice ricensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Premor a Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? jo 4 Pregnant at time of death 5 Other (specify) 9 Unknown should be deta 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 **3**400 this certificate To the Hospital or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Phpatient 2 □ ER/Outpatient 1 ☐ Yes 2 ☑ No 3 DOA ၉ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day 28d. Describe how injury occurred Certification: After 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 137036 1/26/1004 Day / Dawne. of person who completed cause of death (Item 23a) (Type, Print) Drive Chester, MD 2/6/9 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene, 05600 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Day Month Year **Physician** William T. Crawford February 0635 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Annabolis
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Anne Arundel Medical Center Anne Arunde 1

9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral 3**€ M 2 F Director 58 April 27 1945 Maryland 212-44-2124 Usual Residence of Decedent Pages 1 and 2 should be illed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: if item 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumatic event, the Medical Examinar must be nutified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral 17 Victor Parkway 21403 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 TM Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas & College (1-4or 5+) Elementary/Secondary (0-12) 12th Electric Co. n Underground Foreman Leader 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be Leroy Crawford Elizabeth Carter ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State Greta Crawford (Wife) 21403 20a. Method of Disposition D☐Burial 2 ☐ Cremation 3 ☐ Removal from State Bestgate Memorial permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 2/7/04 __ Annarolis, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Sons Mortuary, West St. Annapolis, Md. Wm. Larry & Beese MOG 48 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER Physician nive Wna /Medical Due to (or as a consequence of) months Examiner Sequentially list conditions, if any, leading to animediate cause. Enter Underlying Cause (Disease or rigury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. je je 9 Unknown ۵ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy performed? certificate 1□ Yes 2□No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NO Eds 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Str 300 Besi DR, KNOFF 900 31. Date filed (Month, Day, Year) State 5 2004 FEB 0 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Feb. 2004 **Physician** June L. Chambers 11:15 p M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Arnold Anne Arundel FutureCare Chesapeake | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Jun. 16, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🕮 F 104-24-3250 70 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County in than "natural", or itema 23a or 28a-f show the Modical Examinar must be notified at Millersville MD Anne Arundel 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21108 USA 462 Worthingting Road death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Personnel Manager Department of Defense . Pages 1 and 2 should be filed wi tment of Heatth and Mental Hygien tant: If item 27 is marked other th ijury or other traumatic event, Ita 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unavailable Rhoda Wellman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donna A. Hahn/Daughter 7151 Barry Road, Alexdria, VA 22315 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Feb. 6, 1 Burial 2 Cremation 3 Removal from State Baltimore, MD permit. Page Department of Important: If any injury or once. Metro Crematory 2004 * 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy, 21. Signatur ice Licensee Severna Park Funeral Home Severna Park, MD 21146 23a. Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last aruence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to Box 68760. physician Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 TEctopic pregnancy 2 Fetal death Month Day 5 Other (specify) ☐Yes 2 No o the 9 Unknown þ Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an has autopsy performed? certificate 1 Yes 2 0 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 4 Unursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes Medical Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manne Death After Injury 1 atural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1/Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Atla 06 04 ed cause of ceath (Item 23a) (Type, Print) 30. Name and address of pe OND 101 32. Pogistrar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05602 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** GLADYS BEATRICE COLE FEB. 18 14=42 M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RHARFUND 1)69 HAURE NALE HARFOND HUSPITAL MEMOMAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month Day, Year, April 5, 1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F 212-28-1544 Yrs. **Director** 72 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 10d. Inside City Limits MD Harford Aberdeen Director YQXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 427 Bernice Terrace 21001 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mentel Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) Coltege (1-4or 5+) Homemaker In home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Allen Eugene Murphy Ida Kennard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Robert W. Cole, Jr. 427 Bernice Terr., Aberdeen, MD 21001 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/23/04 Harford Mem. Gdns. Aberdeen, MD ' 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 333 South Parke St., Aberdeen, MD 21001 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** A SCUD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ned by the attending physician and solution and solutions are detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 687 tF FEMALE: Division of Vital Records, P.O. Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ♠ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has birector, page 2 s 24a. Was an 1 Yes 2 No 1 ☐ Yes 2 34No nerel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medicai Certification; To 1 XYes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospitel o within 24 hours aff To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) FEB18, 021809 mish DME K 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PILAB 5 NS TIMONIUM 1+0 2336

State Registrar 31. Date filed (Month, Day, Year)

FEB 2 8 2004

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 05603 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1857 [™] Feb 07 2004 Donald Ernest Crowl /Medical 4c. County of Oeath 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct 13 1917 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days M 2 ☐ F 86 Yrs. MD Director 217-12-1635 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "netural", or Items 23a or 28a-f show other treumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Westminster Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 508 Spruce Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🖾 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Post Office Postal Carrier permit. Pagas 1 and 2 should be fila Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other treumetic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest Longwell Crowl Leda Giggard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice C. Crowl/wife 508 Spruce Avenue Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Leisters Church Cem | 2/11/2004 Westminster, MD 21. Signature of Funeral Service Licensee Pritts funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** SCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No be detached for Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signad by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident tha Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Hospital or A 24 hours after 4 | Homicide within 24 hours af
To the Funaral D
completely filled in 1 🖟 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number WIL D25443 20 completed cause of death (Item 23a) (Type, Print) Poole Road, Westminster MD21157 x 2º middletm 488 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Bloom It Specie Registrar

	,1044		_ For	State of Maryla	nd / Dep	artment of I	lealth and	Mental Hyg	liene 2 A A	05001			
			1 - State Registrar Unpend Item#2	a,27,28a-f,Per	ME, 0829	7,3/92/948f	Death	2. Date of Dea	eg. 140.	4 05604			
	Physici		BARBARA JEAN				ary06, 2004 1448 PM						
3	/Medio		4a. Facility Name (If not institution, give s	street and number)			or Location of Dea		4c. County of Dea	ith			
		1	1 Hickory Lane Ap		In an hindh da	La Pl		O Data of Birth	Charles				
*	Funeral Director		5. Social Security Number 6. Sex 213-46-5133	7. Age (In yrs	54 Yrs.	Months Days	Hours Min		, 1949 MA	rthplace (State or Foreign ountry) RYLAND			
ryland	yland		10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits			
	death with the Maryland ime 23a or 28a-1 show r must be notified at	Director	MARYLAND CHAR	LES			A PLATA		0	1 ₹ Yes 2 □ No			
with	with ti		10e. Street and Number 1 HICKORY LANE	APT#504		10f. Žip Code	20646	'	Og. Citizen of What C				
	death	Funerai		12. Was Decedent Ever in I	U.S. 13.	. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Specify Yes or No-	14. Race - Am Black, Wh				
5-0036	hours after deat tural', or Iteme :	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 3 ☐ Divorced	1 ☐ Yes AONO If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	to ritozii, oto.)	Specify:	WHITE			
2 Pe	요 크림	etec	15. Decedent's Edu (Specify only highest grade	cation completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of we	orking	16b. Kind of Business	s/Industry			
717	I within 72 liene. r than "na!	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	me.		∽ E CLERK		WALDORF	MOTE1			
פ	al Hygi f other vent.	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle,					
<u>X</u>	ould b	2	EDWARD LYNN WI						TTA PICK	-			
Maryland	id 2 shi lith and 27 is m traum		19a. Informant's Name/Relationship (Ty) RANDOLPH G.WII						r, City or Town, State, YWINE, MD				
Č,	ss 1 and of Health item 27 other to		20a. Method of Disposition	20b.	Place of Disp	osition (Name of amatory or other pla	ce)	Date	20c. Location - City o	Town, State			
Ē	nit. Pages artment of ortant: If it injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	ВАҮ	VIEW	CREMATO	RY 2-9	-04	BALTIMOR	E, MARYLAND			
Baltimore,	permit Depart Import any in		21. Signature of Funeral Service License	M00479	0	RAYMOND	FUNERA	L SERVI	CE, P.A.				
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the dealer se on ach line. Mixed Drug In Due to (or as a conse	ntoxicat		ng, such as cardia	ic or respiratory arr	est,	Approximate Interval Between Onset and Death			
50. 1 20.0 20.0	Examiner	ler.	Sequentially list conditions, any leading to immediate cause. Enter Underlying	Due to [or as a cons	quence of);								
ó	be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):									
Ω	the	dicai			· · · · · · · · · · · · · · · · · ·								
O. Box 6	death certif e attending d for use a	ysician/Me	ysician/Me	ysician/Me	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 X Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	olivery Day Year
ds, P	es tha gned se de	by	Partition of the significant containing to death out not resulting in the underlying cause given in react.							o the cause of death?			
Hecords,	The law requiresate has been single 2 should the	Completed						24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of			
		(I)	25. Was case referred to medical				26. Place of De	ath (Check only on	`_	s 2□No			
<u>></u>	Physici this cer al direc	To B	examiner? 1 ☑ Yes 2 ☐ No	lospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatie	ent 3 DOA Oth	ner: 4 🗆 Nursing	Home 5 ☐ Reside	ence & Other (Spe	ecity) At scene			
מכ	ding Ph h. After th funeral	ion:	27. Manner of Death 1 □ Natural 5 □ Pending	128a. Date of Injury 150u(110) nth, Day Year)	found	Wo	ryat rk? Yes 2	0.0400	ow injury occurred				
Division	after death after death Director: / d in by the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	2/6/04 28e. Place of Injury - At I	2:22 home, farm, s	p	103 2 6 110	28f. Location (St	reeted drugs treet and Number or Fi				
2	s after al Direct	Certification:	4 Homicide building, etc. (Specify)					1Hickory I	ane. Apt.504	.LaPlata.MD			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (sicien: To the best of my kn ner: On the basis of examin and manner stated.				e, and due to the ca	ause(s) and manner a	s stated.			
	To the within 2. To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	2	9d. Date signed (Mon	th, Day, Year)			
1	,- > F 0		I him his.	mi		0.C.	ME.		February (07, 2004			
			30. Name and address of person who co	empleted cause of death (Ite			oot D-3	4.5	form-1c=3 01	1201			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature			сшюrе, М	Maryland 2:	LZUI			
	Donich		EEDOO	2004	200	Annet 8	9 .						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Victor D. Daumit 2004 /Medical 4b. City, Town, or Location or Down

H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

July 12, 1918 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 901 BYEAKWATER 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 85 Pennsylvania 577-10-2583 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 901 Breakwater Drive 21403 USA or itema 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Itema 23 12. Was Decedent Ever in U.S. Armed Forces? 1 SYes 2 ☐ No If Yes, Give Year or Dates: 1941–45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dancer Entertainment 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Daumit Miriam Daumit ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty B. Daumit/ Wife 901 Breakwater Drive, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of the Important: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'l. Cem. 2-11-04 Arlington, Virginia 21. Signal of Funeral Bervice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 arwy 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** eviosalerotic /Medical Due to, (or as a consequence of) **Examiner** ens10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed demin use as the burial-tran and resulting in death) Last Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 5 Other (specify) 1 Yes 2 No detached the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 □ Inknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? To the Hospital or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this certifica funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: Other: 4 ☐ Nursing Home 5 X lesidence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. escribe how injury occurred Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide Hed 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29b. Signature and title of certifier reput 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print) address of person who comple ONES 32. Resstrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 5 Registrar

			1 ⊷ State Registrar	State of Maryland		artment of H		ental Hygie		05606	
Ī	Physici	an	1. Decedent's Name (First, Middle, Last)	C				2. Date of Death Month	Day Year	3. Time of Death	
	/Medic		4a. Facility Name (If not institution, give str	ones Sr.		4b. City, Town, or	Location of Death	January	4c. County of Dear		
	LAGIIII			yand Med. C	fr.		nore, Mid)	Balt	imare	
	Funeral Director		5. Sociat Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	tf Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) Co	thplace (State or Foreign	
14	ט		Usual Residence of Decedent					Feb 11,1	945 Mary	land	
	Aarylar F show	ō	10a. State 10b. County		, Town or Lo een An					10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	r 28a-	Director	Maryland Queen Anne	e Qui	een An	10f. Zip Code		10g	. Citizen of What Co	ountry?	
	ath with		313 Mason Branch F	D		2165	7		U.S.A.		
10	Iter de	Funeral	11. Marital Status 12 Married 12	: Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No	S. 13. \	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
99	ours a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		Yes 2X No	Specify:		Specify: Wh	ite	
2	tiled within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23s or 28s-1 show that the Medical Exeminant be notified at	Completed	15. Decedent's Educa (Specify only highest grade of	completed)	(Give	lent's Usual Occupa kind of work done d OO NOT use retired)	uring most of workil	ng 16	b. Kind of Business	Industry	
212	d withing giene.)om	Elementary/Secondary (0-12)	College (1-4or 5+)		Disabled			N/A		
and	d la b	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name				
	should be ind Mental marked o	ပ္	Mervyn Downes 19a. Informant's Name/Relationship (Type	, Print)	19b. Maitin	g Address (Street a		/irginia Route Number, C	Towers ity or Town, State, 2	Zip Code)	
N N	and 2 : ealth ar n 27 Is		Patricia Downes	spouse		ason Bran		ueen Ann		657	
Baltimore, Maryland 21215-0036	Pages 1:	- 1	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rei		ace of Dispo- metery, cren	sition (Name of natory or other place) D	ate 200	c. Location - City or	Town, State	
	Part and		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licensee			co Cemete		/2004 (Greensbor	o,Maryland	
B	permit. Departi	5 /	Mayle (Fe	and	F1	eegle and	Helfenbe Greensbo		al Home P 21639	A	
	P 2		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death cause on each line.						Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sepsis						lwk	
	Examiner			Due to (or as a consequ	e Rec	al Disea	a.			13 month	
	sit ad	iner	Sequentially list conditions, if any, leading to immediate Cause. Chief the Cause (Disease or injury	Due to (or as a cons	ence of):	, , , , , ,					
	execution and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):						
8760	cate be executed obysician and the burial-transit	dlcall	d.								
39 XO	leath certifica attending ph I for use as t	/Med	IF FEMALE:	: If yes, outcome of pregnar	nov						
Bo	death c	ician	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 [Ectopic pregnancy Other (specify)			23d. Date of deli Month	ivery Day Year	
O.	that the de led by the a detached t	ed by Physician/Me	by	9 🗆 Unknown	9□ Unknown				1		
Vital Records,	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as			by	Part II. Other significant conditions control Significant Conditions Signifi	ansplant	Iting in the un	derlying cause give	n in Part I.	23e. Did tobac	
Şec	has be	Completed	,	•				24a. Was an autopsy performed	prior to d	topsy findings available completion of cause of	
ta		a	25. Was case referred to medical				26. Place of Death	1 ☐ Yes 2		2 □ No	
<u> </u>	tending Physicien: The teath. foath. tor: After this certificate hathe funeral director, page	To B	examiner?	spital: 1 Inpatient 2 E	ER/Outpatien	3□ DOA Othe	6		e 6 □Other (Spec	eify)	
UC C	ding P. h. After t funera	tlon:	27. Manner of Death 1 Naturat 5 ☐ Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Intury	28c. Injury Work	at 2 ? es 2 □No	8d. Describe how i	njury occurred		
Division of	Atten	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At hor building, etc. (Specify)	me, farm, stre			8f. Location (Stree City or Town, S	t and Number or Ru	ral Route Number,	
	oital or urs afte rel Dir iled in										
	To the Hospital or Attending Physicien: Thin 24 hours after death. To the Funerel Director: After this certification of the funerel Director. After this certification is not the funeral director.	edical	29a. Certifier (Check only one) 1X Certifying Physic (Check only one)	r: On the best of my know r: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License		29d.	Date signed (Month	i, Day, Year)	
			Yand freelow	no Reside	nt		16637		130/04		
			30. Name and address/of person who com			orint) n Greene	St R-1+	imore, MI	21201		
3	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure	- A. A	or Dail	Amore, MI	21201		
10/2	Registr	ar	FEB 2 2004	for 30 13		and the					

Amended Item 1 per Physician 02/09/2004 Carroll County, wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland	d / Depa <i>Cei</i>	artme rtifica	ent of He ate of D	ealth ai Death	nd Menta		ene 2	004	0560
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last	ANC C	RANK	CASSE	,	ENGEL		Feb	e of Death oth Oruary		Year 2004	3. Time of Death 6:14 P M
	Examin ———— Funeral	er	4a. Facility Name ∤If not institution, give Frederick Memoria 5. Social Security Number 6. Se	al Hospita y 7. Ag		ast birthday)	Fre	ederic der 1 Year	k If Under 2	4 Hrs. R Date	e of Birth	Fred	derick	lace (State or Foreign
۵.	Director		220-26-5782 Usual Residence of Decedent	M 2□F	92			s Days	Hours	Min. Dec	nth, Day, Y 13,	1911	1 Mary	land
	the Marylan r 28e-f show notified at	Director	MD Frederic 10e. Street and Number	ck		ederic	k	Zip Code			10g	. Citizen of	f What Cour	0d. Inside City Limits 1 ☐ Yes 2 🕱 No htry?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If itam 27 is marked other than "naturel", or Items 23a or 28e-f show or other treumatic event, the Medical Examinar man be notified.	by Funeral D	6441 Jefferson Pi 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 11 Yes 2 U If Yes, Give Year or Dates:			Was De	21702 cedent of His pecify Cuban 2)(2) No	spanic Origi n, Mexican, Specify:	in? (Specify Ye Puerto Rican, e	s or No-		ace - Amend lack, White,	etc.
Maryland 21215-0036	within 72 hours ene. than "naturel", be Medical Ex	Completed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation		16a. Deced (Give life.	kind of DO NO1	sual Occupa work done di use retired)	uring most	-	16		Business/Ind	
yland 2	2 should be filed withir and Mental Hygiene. is marked other than eumatic event, the Mental and	To Be Co	17. Father's Name (First, Middle, Last) Charles Edwin Er			*			18. Mother	s Name <i>(First</i> , garet E	lizab	eth N	ame) Nicode	
re, Mar	s 1 and 2 sh f Health and ftem 27 is m other treum		19a. Informant's Name/Relationship (T) T. Hugh Engel - 20a. Method of Disposition	son	20b. Pl		Key	SVIII	e Rd.	or Rural Route , Keyma Date	r, MD	2175		
Baltimore,	permit. Pages 1 an Department of Heal Importent: if itam 2 any injury or other once.		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. S nature of Funeral Service Licens	A		l Coun	ty (remat	ion 2 s of Facility	nai tz	ler F	unera	1 Hom	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each li	the death	n. Do not ent				nion Br ardiac or respir			1791	Approximate Interval Between Onset and Death
vg ²	/Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events	b. Due to (or a) Due to (or as	.DioJ	Asul	M	Disen	ડ હ					
8760,	death certificate be executed e attending physician and id for use as the burial-transit		resulting in death) Last	Due to (or as	a consequ	uence ot):								
.O. Box 6	0 0	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic Other	pregnancy (specify)				1	ate of delive	ory Day Year
ords, P.	w requires that the been signed by th should be detache	ted by Pł	Part II. Other significant conditions co	ntributing to death b	ut not resu	alting in the u	nderlying	g cause givei	n in Part I.	230	a. Did tobac		ntribute to th	e cause of death?
tal Reco	The law ate has b page 2 sl	e Comple	25. Was case referred to medical						26 Place	_			were autoprior to condeath?	psy findings available npletion of cause of
Division of Vital Record	ding Phys h. After this funeral di	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	ry y Year)	ER/Outpatien 28b. Time of Injury	М	DOA Other	r: 4□ Nurs	28d. De	Residence Residence Residence	injury occu	urred	
DIVI	Hospital or Attendest hours after death Funeral Director: tely filled in by the		4 Homicide determined	28e. Place of Inj building, et sicien: To the best					a date and	City	or Tòwn, S	State)		I Route Number,
	To the Hospital or Attenwihin 24 hours after deat To the Funeral Director:	Medical	(Check only one) 29b. Signature and title of certifier	iner: On the basis o	f examinat	tion and/or in	vestigati	on, in my opi	inion, death	occurred at the	time, date	and place	nanner as st e, and due to led (Month, I	the cause(s)
	WIL		30. Name and address of person who c	(asug-	WW.	23a) (Type,	Print)		0307 _Euge			2	5/00	+
	Sta		31. Date filed (Month, Day, Year)	32. Region	-		Ke	F.	re	ne B. C	K,	201	3	1703
C:	Registr	al	FFB 0 9	2004		15	6100	w						

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State of Maryland / Department of Health and Mental	Hygiene 2004

			State of Maryland / Depart	ment of Health and M ficate of Death	ental Hygien		05608
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
20	Physici		CATHY JO EDWARDS		Month D February	y 16 200	4 1:50p ^M
	/Medic			b. City, Town, or Location of Death		c. County of Death	
			Chester River Hospital Center	Chestertown		Kent	
15	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	f Under 1 Year If Under 24 Hrs. Ionths Days Hours Min.	8. Date of Birth (Month, Day, Yea	r) Coun	lece (State or Foreign try)
v),ilie	Director		218-70-3828 1 1 M 26 F 46 Yrs. 1 W 28 F 46 W 28		June 15	1957 Del	.aware
	land	1	10a. State 10b. County 10c. City, Town or Locati	ion		1	0d. Inside City Limits
	Mary 	ţo	MD Kent Chestert	own			1 May Yes 2 □ No
	r 28a	irec		10f. Zip Code	10g. 0	Citizen of What Coun	itry?
	h with	a D	407 B Morgnec Rd.	21620	U.	.S.A.	
	dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 15 Yes	s Decedent of Hispanic Origin? (Spe es, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Americ Bleck, White,	
9	or It	J.	1 Never Married 2 Married 1 Yes 2 No	Yes 21 No Specify:		Specify: Wh	ite
8	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f ehow then "natural" Exemple in the multied at	Completed by Funeral Director	3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent	t's Usual Occupation	16b	Kind of Business/Inc	dustor
5	in 72	lete	(Specify only highest grade completed) (Give kind life, DO	d of work done during most of workii NOT use retired)	ng los.	14114 07 0301110001111	3331,4
77	iene.	mo d	Elementary/Secondary (0-12) College (1-4or 5+) 2 So	cial Worker	S	elf-Empl	oyed
D	Hygir other	BeC	17. Father's Name (First, Middle, Last)		(First, Middle, Maide	an Sumame)	
<u>lar</u>	uld be Mental irked c	ToE	C. Joseph Edwards Sr.	Jean Pi	ratt		
ary	2 should and Men is marks aumatic			Address (Street and Number or Rura	-		
Σ,	1 and 2 Health term 27 i		Angela Maloney (daughter) 4607				
Baltimore, Maryland 21215-0036	ges H of	1070	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	ory`or other place)		Location - City or To	
Balt	permit. Pa Dep ritmer Importent: any injury once.		21. Sign from Funy ral source to need M00510 Ga 1	ame and Address of Facility Lena Funeral H 3 West Cross S	ome of S t. Galen	tephen !	L Schaech 21635
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the shock, or heart/failure. List only one cause on each line.	he mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause Final disease or condition	gan Systom	Failu	re	Onset and Death
2	/Medical		resulting in death) Due to (or as a consequence of):				> > C
ł,	Examiner		Sequentially list conditions, b. TYOVQX (G	111011054			> 50mms
7	pe, tis	Examlner	if any, leading to immediate daughter and the cause. Enter Underlying Cause (Disease or injury				
1	and and II-tran	хап	that initiated events resulting in death) Last Due to (or as a consequence of):				
8760	icate be executed physician and the burial-transit	a E					
687	ficate physics the	edical	d				
Box (the death certificate be executed y the attending physician and tched for use as the buriat-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ry
	death	icla	in the past 12 mopths? 4 Pregnant at time of death 5 Of	topic pregnancy ther (specify)		Month	Day Year
P.0	that the de ed by the detached	hys	9 ☐ Unknown				
	uires tha signed d be de	by F	Part II. Other significant conditions contributing to death but not resulting in the unde	orlying cause given in Part I.		o use contribute to th	
ord	w require		OS FOODO POSIS		1 Tes	2 No 3 Prob	ably 4 □Unknown
Vital Records,	g 2 ℃	Completed	mainitrition		24a. Was an autopsy	prior to cor	psy findings available npletion of cause of
HH		Con			performed?		2□ No
Vita	Physicien: Trips certificated fall director, p	Be	25. Was case referred to medical example? Hospital:	26. Place of Death			
of	this al du	- To	1 ☑ 9 es 2 ☐ No ☐ Nospital 1 ☑ Inpatient 2 ☐ ER/Outpatient 27. Manngrof Death 28a. Date of Injury 28b. Time of	3 DOA 4 Nuising Hor	me 5 Residence 28d. Describe how in		/)
on	ding h. After	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 □ Yes 2 □ No		,,	
Division	il or Attending after death. I Director: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street,	t, factory, office	28f. Location (Street	and Number or Rura	I Route Number,
<u> </u>	i ji te o	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Sta	ife)	
	To the Hospital or Attent within 24 hours after deat To the Funerel Director: completely filled in by the	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death or control of the basis of examination and/or investigation and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. E	Date signed (Month,	Day, Year)
)		15	Marel	D005883	14	2/17/0	16/
	M		30. Name and address of person who completed cause of death (Item 23a) (Type, Printing 23a)				(
			Paul Donaher MD 119 C North Ma:	in St. Galena,	MD. 216	35	
	Sta Regist		31. Date filed (Month, Day, Year) a2. Registrar's Signature				
	negist	al	FEB 2 3 2004 See & April				

		For State Registrar	State of Maryland	/ Departmer Certificat	nt of Health and te of Death	rieg.	ne 2004	
Physicia	an	Decedent's Name (First, Middle, La	st)			2. Date of Death Month	Day Year	3. Time of Death
/Medic	al	Walter James Fies		45.00	Town and postion of Doo		5 2004 4c. County of Death	3:00 p
Examin	er	4a. Fecility Name (If not institution, giv			Town, or Location of Dea			
uneral		Anne Arundel Medi 5. Social Security Number 6. S		t birthday) If Unde	polis r 1 Year If Under 24 Hr	s. 8. Date of Birth	Anne Arun	nplece (State or Foreig untry)
irector		213-12-3953 Usuel Residence of Decedent	™ ^{2□ F} 83	Yrs. Months	Days Hours Min		1920 Mary	
how		10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limit
"natural", or items 23a or 28e-f show olical Extrainer must be notified at	Completed by Funeral Director	Maryland Anne Aru	ndel Annapo		0.1	10-	. Citizen of What Co	1 ☐ Yes 2 🖾 N
a or 2	ä	10e. Street and Number		2140	p Code			•
ns 23	era	116 Rosecrest Dri	12. Was Decedent Ever in U.S.		edent of Hispanic Origin? (ecify Cuban, Mexican, Pue		ited State 14. Race - Amer	ncan Indian,
aher	Fun	1 ☐ Never Mamed 2 ☐ Married	Armed Forces? 1X1Yes 2□No 194;	2-		rto Rican, etc.)	Black, White	
ral', o	by	3 Widowed 4 □ Divorced	Year or Dates: 194.	1 ⊔ Yes	2 No Specify:		Specify: Wh:	ite
"natural",	etec	15. Decedent's E (Specify only highest gra		16a. Decedent's Usu (Give kind of w	ork done during most of wi	orking 16	b. Kind of Business/I	ndustry
	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	iife. DO NOT u	use retired)		a a	
marked other than		17. Father's Name (First, Middle, Last		rinter	18. Mother's Na	me (First, Middle, Ma	S. Governm iden Sumame)	nent
arked o	To Be	Edward E. Fiesele			Helen B	Suit		
it of neatities and mental righteries. If flem 27 is marked other than or other traumatic event, the M.	F	19a. Informant's Name/Relationship (19b. Mailing Addres	ss (Street and Number or F		ity or Town, State, Z	ip Code)
27 is r trat		Kenneth Fieseler	/ Son	116 Rosec	rest Drive	Annapolis,	Maryland	21403
item		20a. Method of Disposition	20b. Plac	ce of Disposition (Na netery, crematory or	other place)	Date 20	c. Location - City or 1	Town, State
nt: H ry or		1 N Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specie	Indinoval nom State	crest Memo	(/2004 Ani	napolis, l	Maryland
Important: if item 27 is eny injury or other trai		21. Signature of Funeral Service/Life	1500		uke of Glouc	ohn M. Tay	lor Funera	al Home,
25 - 7		23a. Pert1. Enter the disease, or comshock, or heart failure. List only	plications that caused the death.					Approximate Interval Between
ysician		Immediate Cause (Final disease or condition		Dreumon	·(u			Onset and Death
ledical		resulting in death)	Due to (or as a conseque	nce of):				100-
aminer		Sequentially list conditions.	b					
sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):				
and I-trans	Examiner	that initiated events resulting in death) Last	c	nce of):				
ician buria	ical E		550 10 (51 25 2 551)05430					
phys s the		•	d					
attending physician and for use as the burial-transit	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance				23d. Date of deli	very
signed by the atter id be detached for t	Physician/Med	in the past 12 months? 1 Yes 2 No	1□Live birth 2□Fetel d 4□Pregnant at time of dea 9□Unknown				Month	Day Year
ed by deta	h h	Part If. Other significant conditions	ontributing to death but not resulti	ing in the underlying	cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
n sign	d by	Chramaber otes	- wilmoney less	ire		1 (5 Pes	2 No 3 Pro	bably 4 Unkno
should should	Completed					24a. Was an	24b. Were au	topsy findings availa
page 2	шс		-			autopsy	d? death?	omptetion of cause
certificate rector, pag	0	25. Was case referred to medical			26 Place of D	1 ☐ Yes 2 2 eath (Check only one)	No 1 ☐ Yes	2 140
director,	0 8	examiner? 1 ☐ Yes 2 ŞeNo	Hospital: 1 Papatient 2 EF	R/Outpatient 3 D	Other	Home 5 ☐ Residence	e 6 □Other (Spec	ify)
n. After this funeral dir	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury at Work?	28d. Describe how		
death. ctor: Afi y the fur	atic	2 Accident investigation	n	M	1 ☐ Yes 2 ☐ No			
Directory of the point of the p	Certification:	3 Suicide 6 Could not to determined		e, farm, street, facto	ry, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C		nysician: To the best of my knowledge: On the basis of examination					
thin 2 the mple	Med	29b. Signature and title of cartifier	and manner stated.	29	9c. License number	29d	. Date signed (Month	, Day, Year)
₹ ¥ 8		A War	comme		032036		2/6/2007	
		, , , , , , ,			~ J 2 1 1 10			
		20 Name and address	completed cause of death /tic-	3a) (Tuna Dian)				
		30. Name and address of person who	completed cause of death (Item 2	23a) (Type, Print)	Ir we Cherh	m01/1	19	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes a print of Health and Mental Hygienes and Mental Hygienes are the state of Maryland / Department of Health and Mental Hygienes are the state of Maryland / Department of Health and Mental Hygienes are the state of Maryland / Department of Health and Mental Hygienes are the state of Maryland / Department of Health and Mental Hygienes are the state of Maryland / Department of Health and Mental Hygienes are the state of Maryland / Department of Health and Mental Hygienes are the state of Maryland / Department of Health and Mental Hygienes are the state of Maryland / Department of Health and Mental Hygienes are the state of Maryland / Department of Health and Mental Hygienes are the state of Maryland / Department of Health and Mental Hygienes are the state of Maryland / Department of Health and Mental Hygienes are the state of Maryland / Department of Health and Mental Hygienes are the state of Maryland / Department of Health and Mental Hygienes are the state of Maryland / Department of Health and Mental Hygienes are the state of Mental Hy

					State of	Maryiai	na / Depa <i>Cel</i>	arument d rtificate	of l	Death	Mental H	Reg. No.	200	4 (05610
			Decedent's Name (First, M.	iddle, Lasi	t)						2. Dete of D	eeth			3. Time of Death
	Physicia		Dennis	We	ston	1	FRIEND				Februa	Day	2, 200		2 55 PM
	/Medic Examin		4a Fecility Name (If not instit						4	b. City, Town, or	Location of Dee		County of D		
	LXamiii	CI	Garrett Coun	ty Me	morial	Hospi	tal			0a	kland			Garı	rett
	Funeral		5. Social Security Number	6. Se	X		. lest birthday)	If Under 1 \ Months D	Year Days	If Under 24 Hrs Hours Min		rth	9.	Birthplece	e (State or Foreign
	Director		220-52-9607		3 M 2□ F	54	Yrs.	IVIONO13	,uy3	110010	Feb. 1	Ó, 19	49	Mary	land
	pu &		Usual Residence of Deceder 10a. State 10b. Co			10c C	ity, Town or Lo	eation						10d	Inside City Limits
	sho	ŏ		,		1.00.0	,,		7 + 4	imore					1⊠Yes 2□No
	28e-	Funeral Director	MD 10e. Street end Number					10f. Zip Co		rmore		10g. Citiz	en of What	Country	?
	With a second	ā	206 Laurens	C+	#2					21217			111	SA	
	death Tre 2	Jera	11. Maritel Status	51.,	12. Was Dece	dent Ever in t	U,S. 13.	Was Deceden	t of H		Specify Yes or N rto Rican, etc.)	0- 1	14. Race - A	American I	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Herne 23a or 28e-f show ent, the Medical Examinat must be motified at	by Fur	1 Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		Armed For 1 Tes If Yes, Giv Yeer or Da	2 🔯 No e		r Yes, speciny 1□ Yes 212			no Hican, etc.)	1	Specify:	Vhite, etc. White	
Maryland 21215-0036	n 72 hours aff "natural", or edical Exam	Completed by	15. Dece (Specify only h	dent's Edu	ucation de completed)		16a. Deced	dent's Usual C	occupi	etion during most of wo	orking	16b. Kir	nd of Busine	ess/Indust	ry
2	d within giene.	ap.	Elementery/Secondary (0-		College (1	-4or 5+)	life.						Pos	taura	on+
121	filed within Hygiene. ther than	S	17. Fether's Neme (First, Mid	dle Lest)	3			wa	ite		ame (First, Middl	Maiden .		Laura	ant
anc	S E S	o Be			. La attacas	T.	riend			Virgi		Elo		Not	wlon
2	d 2 should th and Men 7 Is marke traumatic	۲	Weston 19a. informant's Name/Rela		ebster	F.		na Address (S	treet a		Rurel Route Num				
	and 2 s ealth an n 27 Is	- 1	Crystal D. C			er					Cumbe				
ē,	f Hea		20a. Method of Disposition			20b.	Place of Dispo	sition (Name	of or plac	ee)	Date	20c. Lo	cation - City	or Town,	State
mo	Page national nrt: If		1 ☐ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Other			state	meba Cı			-,	2/ /04	Mor	ganto	wn	WV
Baltimore,	permit. Pages 1 and 2: Department of Health ar Important: If Item 27 Is any Injury or other trau		21. Signature of Funeral Ser	vice Licens	900			2. Name and A		,	Stewar				
			23a. Part1. Enter the disees	J-	Delita	J					0aklan		215		proximate
	Dharistan		shock, or heart failure.	List only o	ne cause on e	ech line.	itii. Do not ent	er the mode o	и ступт	g, such as cardia	ic or respiratory	211031,		Int	erval Between nset and Death
	Physician /Medical		Immediate Ceuse (Final disease or condition		Pneu	monia								2 1	weeks
п	Examiner		resulting in death)		е	Due to	(or es e consec	quence of):						1	
	sit ad	edicai Examiner			AIDS									yea	ars
	tificate be axecuted g physician and as the burial-transit	хап	Sequentially list conditions, if eny, leading to immediate			Due to ((or es a consec	quence of):						1	
68760,	s be a slcian b burit	calE	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events	<	C	Due to (or es a conseq	mence of).						-	
	ifficate g phy as the		resulting in death) Last			Due to (or es a conseq	derice ory.						Í	
Вох	attanding attanding for use as	S S			d					- 14				1	
	daat na att ed fo	SICI	Part II. Other significant con	ditions co	ntributing to de	ath but not re	sulting in the u	nderlying caus	se giv	en in Part I.	23b. Dio	l tobacco	use contrib	ute to the	e cauae of death?
P.0	The law requires that the death cert ate has been signed by the attendin page 2 should be detached for use	/ Physician/M	Metastatic l	ung	Cancer						1	Yes 2	□ No 3□	Probab	ly 4∏ Unknown
Records,	uires sign	d by										s en autop	sy 24		autopsy findings
00	v require been si should	ete									per	ormed?		compl of dea	ble prior to letion of cause lth?
æ	The law sate has page 2:	Completed									- 10	Yes 2½	EN6	1 🗆 Y	es 2 No
Vital		Bec	25. Was case referred to me	dical						26. Place of De	eath (Check only	one)			
of V	G is S	70 E	examiner? 1 ☐ Yes 2 2 No		Hospital:	npatient 2	☐ ER/Outpatier	nt 3DOA	Oth	er: 4 🗆 Nursing	Home 5□Res	idence 6	Other (S	Specity)	
	5 p		27. Menner of Death 1 ☑ Natural 5 □ Pe 2 □ Accident	nding estigation	28a. Date of	of Injury h, Dey Year)	28b. Time of Injury	f 28c.	Injun Worl	yet k? Yes 2 □ No	28d. Describe	how injury	occurred		
Division	or Attending after death. Director: Aftel in by the fune	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be termined	260. Place	of Injury - At I	home, farm, str ify)	eet, factory, o	ffice		28f. Location City or To	(Street and own, Stete)		r Rurel Ro	oute Number,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	edical Ce	29a. Certifier 1 Certifier (Check only 2 1	it ying Phy	rsicion: To the	st of my kn	owledge, death	n occurred at t	the tim	ne, date and pled	e, end due to the	ceuse(s)	and manne	r as stete	d. e cause(s)
	ithin 24 o the Fl	Med	29b. Signature and title of ce	11	andmann	er stated.				e number	curred at the time		signed (M		
	o viil			Y			7	T.	239	270		02/	02/200	24	
	1	7	30. Name end address of page	son who c	ompleted caus	e of deeth (Ite	em 23e) (Type,		(ر ـــ	, , ,		027	02/200	J4	-
	•		Robert A. C	orals	ski, M.	D. 31	1 N. Fo	ourth S	tre	eet Oak	land, MI	21:	550		
	Sta		31. Date filed (Month, Dey, Y			egistrer's Sign		A							
	Registr	ar	I L D	11	LUUT	SER WALL	100	Court	7						

DHMH 16 Rev 6/95

ORIGINAL

			1 - For State Registrar	State	of Maryland	l / Depa <i>Cer</i>	artment of Hetificate of L	ealth and Death	Mental Hy	giene Reg. No.	200	4 05	611
	n. Dhuain		1. Decedent's Name (First, Midd	le, Last)					2. Date of De		Yee	3. Time of	Death
	Physici /Medi		George Rudolph	Gardine	r				Februa			04 2:5	5 A M
A.	Examir	ier	4a. Fecility Name (If not institution	n, give street and r	number)		4b. City, Town, or	Location of Deat			County of De	eth	
			Anne Arundel 5. Social Security Number	Medical (Center 7. Age (In yrs. las	et hirthday)	Annapoli If Under 1 Year	S If Under 24 Hrs	8. Date of Bir		nne Ar		- Francisco
	Funeral Director			1 @ M 2□F		Yrs.	Months Days	Hours Min.		y, Year)		inthplace (State of Country) Jashingto	_
18	ס		213-16-0570 Usual Residence of Decedent						Dec. 2		J J V	asiiriigu	JII, IX
	arylar ehow	_	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside Ci	
	28a-f	Director	Maryland Anne	Arundel	Anna	polis	T						2 🗌 No
	with I			_ 1			10f. Zip Code 21401			_	en of What ced St	•	
	death me 23	Funeral	1613 Cedar Par	12. Was De	ecedent Ever in U.S.		Vas Decedent of His	spanic Origin? (S	Specify Yes or No			nerican Indian,	-
39	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show aumatic event, the Westlest Examinatinal be notified at	by Fur	1 ☐ Never Married 2 Mar 3 ☐ Widowed 4 ☐ Divorced	ned 1 Yes	Dates:	1	Yes, specify Cubar	Specity:	to Rican, etc.)		Black, W. Specify: W		
21215-0036	72 ho	Completed	15. Deceder (Specify only highe	nt's Education	d) WWII	16a. Deced	ent's Usual Occupa	tion	rtina	16b. Kir	nd of Busines	s/Industry	
2	ithin 796.	nple	Elementary/Secondary (0-12)		(1-4or 5+)	life. D	kind of work done di OO NOT use retired)		rking	⊥ 1	+		
2	filed w Hygier other th		12	()		a	ccountant				neater		
Maryland	d be fi	Be	17. Father's Name (First, Middle,						me (First, Middle,		Sumame)		
Ž	s 1 and 2 should f Health and Men item 27 is marks other traumatic	은	Franklin C. G			19h Madin	g Address (Street ar		(unknown		Tour State	Zin Code)	
	and 2 she salth and n 27 is m		Lee Lears/ son				Cedar Pa						
ē,	s 1 and 3 of Health item 27 other tr		20a. Method of Disposition			ce of Dispos	sition (Name of patory or other place		Date			r Town, State	
Ē	m 0 b-		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (5		m State	•	Cremator	1	_04	Ra l	timore	- MD	
altimore,	permit. Pages Department of Importent: If I any injury or once.		21. Signature of Funeral Service	Licensee	· Dair		Name and Address		ohn M. T			•	e. Inc
m —	88 5 8		y. Sist	Komer	nodu	14	7 Duke of						
O.			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause or	t caused the death.						-	Approximate Interval Bet	e ween
i.	Physician		Immediate Cause (Final disease or condition	a.) he	inme					Onset and I	Death
п	/Medical Examiner		resulting in death)	Due t	o (or as a conseque	nce of):							
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	nted Insit		Cause (Disease or injury	<	0.10.10.10.10.10.10.10.10.10.10.10.10.10								
,	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due t	o (or as a conseque	nce of):							
8760,	te be ysicia ne bur	dlcai		d									
9		Med	IF FEMALE:									- 11 - 12	
Вох	death certific e attending p id for use as	Physician/Me	23b. Wes decedent pregnant in the past 12 months?	1 ☐ Live	outcome of pregnance birth 2 Fetal de	eath 3 🗌	Ectopic pregnancy			2;	3d. Date of d	,	rear .
0	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pre	gnant at time of deat known	th 5□	Other (specify)				MONIT	Day 1	ваг
٦.	law requires that the as been signed by th 2 should be detache		Part II. Other significant condition	ons contributing to	death but not resulti	ing in the un	deriving cause giver	n in Part I.	23e. Did to	bacco us	e contribute	to the cause of d	eath?
Hecords,	uires sign	d by		•			, , 3		1 🗆 1			Probably 4 □U	
Ö	w require been si should t	ete							24a. Was	20	24b Wara	utopsy findings a	available
	0 - 2	Completed							autop perfo	med?	prior to death?	completion of ca	luse of
Vita	ilcien: Th certificate rector, pag	a l	25. Was case referred to medica					26 Place of Dea	1 ☐ Yes ith (Check only o	2 2400	1 ∐ Ye	s 2 No	
	di is	To B	examiner? 1 ☐ Yes 2 ဩ♣lo	Hospital:	Inpatient 2 EP	NOutpatient	Other		ome 5□Resid	-	□Other (Sp	ecify)	
n of			27. Manner of Death 1 → Matural 5 □ Pendir	(8.40	e of Injury 28 onth, Day Year)	8b. Time of Injury	28c. Injury a Work?	at	28d. Describe h				
<u> </u>	Attending ir death. ector: After by the fune	catl	2 Accident Investi	gation not be				es 2 □ No					
Division	or Atten after deat Director: in by the	Certification:	4 Homicide determ	inad 286, Plac	ce of Injury - At home Iding, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow		Number or F	Rural Route Numb	ber,
	To the Hospitel or All within 24 hours after or To the Funerel Direct completely filled in by		29a. Certifier 1 Pertifyir	a Physician: To t	he best of my knowle	adna daath	occurred at the time	data and place	and due to the				
	e Hos 24 h e Fur letely	edical	(Check only 2 Medical one)	Examiner: On the	basis of examination	n and/or invi	estigation, in my opin	nion, death occu	rred at the time,	ause(s) a date and p	lace, and du	s stated. e to the cause(s)	,
	within To th	Me	29b. Signature and title of certifie	r			29c. License					th, Day, Year)	
•			KY MX	ALMILE	wo		0	3793	6	21	4/2	004	
			30. Name and address of person		1	3a) (Typę, P	Print)	λ	6 Cher	,			
			Garys	-1100-	e 2108	> ()	1) over	131/105	Cher	-61	MU .	1619	
*	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 5		egistrar's Signatur	A	out,						

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar 05612 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 1, **Physician** NEVA EVELYN GEORG 2004 6:25 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST VINCENT de PAUL NURSING CENTER FROSTBURG ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. May 27, 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1 ☐ M 212 F 215-34-4688 Director Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other then "neturel", or items 23a or 28e-f show treumatic event, the Medical Examinat must be notified at 1 ¥ Yes 2 No Director MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21536 20 N. Pennsylvania Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or item eny injury or other treumatic event, the Wedical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ₩ Widowed 4 Divorced Year or Dates: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Librarian Public Library 12 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alvey Blaine Wilburn Bertha Cross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 699 Grandview Dr., Hyndman, PA Dennis L. Georg/son 15545 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery Feb 4, 2004 Accident, MD A ☐ Donation 5 ☐ Other (Specify) 21. Signature of Tuneral Service bigs 22. Name and Address of Facility.
Newman Funeral Homes, P.A., PO Box 275 eun ei 179 Miller St., Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician UREMIA days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) n signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sign Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? cate has b page 2 s certificate 2 No 1 Yes 1 Yes 2 []1No Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this : After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Directors, completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 1)25638 em 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Creek S. W Frodling Mary lamo CHANG MY 10701 New Hetras SATURNINA 31. Date filed (Month, Day, Year) 32. Registr s Signature State FEB - 6 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 05613 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 15 /Medical 4a. Fecility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner LURSING HOME ENTON 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number Funeral Min. 1 M 2 □ F Months Days Hours 218-05-046 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County th and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-f show traumatic evant, the Medical Examination talket withing at 1 ☐ Yes 2 No Director IYYD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SH Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 O No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MAILMAN 18. Mother's Name (First, Middle, Maiden Surname, Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Health and Mental em 27 is marked o ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 SMITHVILLE ROAD, FE nt of Health a YNNIEGAMBRILL IWI FI other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ö 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. ILLCREST CENTER * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalur of uneral Service Licensee 3115.MAINSI FEDERALSAL mo 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, Physician/Medicai attending a IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 🗆 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 1 √No 24a. Was an has autopsy certificate Chronic 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation death. 2 No 24 hours after deat Funeral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-28-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2004 Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 05615 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month Physician DOROTHY A. HARPER 5,35 PM /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner Randallstown Baltimore Genesis Elder Care Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Deys Months Hours 1 ☐ M 2 📆 F 81 Yrs 217-46-3566 March 4,1922 Director Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County Randallstown MD Baltimore 1K Yes 2 □ No Funeral Director 10e. Street end Number 10f. Zip Code 21133 10g. Citizen of Whet Country?
United States 9109 Liberty Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 White 1 ☐ Yes 21☐XNo Specify Specify: Be Completed by 3 Widowed 4 Divorced Year or Detes: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Milton M. Harper Gladys Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 516 Manor Road, Glen Burnie, MD 21061 Naomi H. Morgan/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Unity-Washington Cem. 2/6/04 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses 22. Name and Address of Fecility 21. Signatu Framptom Funeral Home, <u> 216 Ñ. Main St.Federalsburg,MD</u> 21632 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of): edical Certification: To Be Completed by Physician/Medical Examiner Physician: The law requires that the death certificate be executed sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 24 hours after death.

Funeral Diractor: After this certificate has I letely filled in by the funeral director, page 2: 1 🗆 Yes 2 NO 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 27. Menner of Death Hospital or Attending Maturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕯 certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signeture end title of certifier 2 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) GREENE 72E 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State 9 2004 Registrar

	Registrar			Certific	cate of	Death		. No. 200	
	i. Decedent's Name (First, Middle, Li						Date of Death Month	Day Year	
				4b.	City, Town, o	or Location of Deat	7ebruary		
			PITAL		4	1 1	ND	MILEG	*
5	Social Security Number 6.	Sex 7. Age		Mor			8. Date of Birth (Month, Day, Y	9. B	irthplace (State or Foreig
_	214 46 3039		91	113.			MAY / 19	12 MA	RYLÁND
	0a. State 10b. County		10c. City, Town	n or Location	1				10d. Inside City Limit
		IY	FROSTB						1 □ Yes 2 No
1	TENNANTS LANE			10			10g		Country?
1	1. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was D		lispanic Origin? (S	Specify Yes or No-	14. Race - Arr	
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2	0a. Method of Disposition		20b. Place of	Disposition	(Name of				
2	21. Signature of Funeral Servide Lice	nsee		_					
	7 Janlou 7	M. Xou	vess						, MD 21532
- 11	snock, or near tailure. List only	plications that caused one cause on each lin	the death. Do n	not enter the	mode of dyin	ng, such as cardiad	or respiratory arrest,		Approximate Interval Between Onset and Death
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	esulting in death) Last	Due to (or as a	consequence o	of):					
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II		23c. If yes, outcome of	of pregnancy	Helife E. S.				224 224 444	
2	in the past 12 months?	1 ☐ Live birth : 4 ☐ Pregnant at	2 Fetal death			,		Month	Day Year
·L	9 Unknown	9□ Unknown							
	A 8 9		1	the underlyi	ng cause giv	en in Part I.	23e. Did tobacc	co use contribute t	o the cause of death?
-	Havimcea	Demer	Ma				1 Tes	2 □ No 3 □ P	robably 4 Unknow
							24a. Was an autopsy	prior to	utopsy findings available completion of cause of
									2 NO
	examiner?	Hospital:	- 5-5-0		Othe				
		1 A inpatier		ime of	28c. Injury	/ at	ome 5 Residence 28d. Describe how in	6 Other (Spe	cify)
	1 Natural 5 Pending 2 Accident investigation		Year) In	ijury M	Work	k?		,.,	
		286. Place of inju	ry - At home, fan . (Specify)	m, street, fac	ctory, office		28f. Location (Street City or Town, St	and Number or Rate)	ural Route Number,
2	Check only 2 Medical Exal	niner: On the basis of	examination and	death occur Vor investiga	red at the tim tion, in my op	ne, date and place, pinion, death occur	, and due to the cause rred at the time, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)
		and manner stat	ed.						
	0	ni MO)						*
-			ath (Item 23a) /	Type Print)	5 00	27363	-	ED 14,2	-604
30	0. Name and address of person who	completed cause of ne							
		EDNA MAY HA 4a. Facility Name (If not institution, git \$\int A C R = \int H = \int \text{ 5. Social Security Number}	EDNA MAY HAGER 4a. Facility Name (if not institution, give street and number) SACRED HE ARTHOS 5. Social Security Number 6. Sax 214 46 3039 Usual Residence of Decedent 10a. State 10b. County MARYLAND ALLEGANY 10e. Street and Number TENNANTS LANE 11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last) FRANK J. LASHBAUGH 19a. Informant's Name/Relationship (Type, Print) CARL R. HAGER / GRANDSON 20a. Method of Disposition 1 Rurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Bervide Licensee 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each in Immediate Cause (Final disease or condition resulting in death) 1 Sequentially list conditions, frairy, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Part II. Other significant conditions contributing to death but Advisor and the polynomial of the condition	EDNA MAY HAGER 4a. Facility Name (If not institution, give street and number) 5. Social Security Number 5. Social Security Number 6. Sex 214 46 30 39 1	EDNA MAY HAGER 4a. Facility Name (if not institution, give street and number) 5. Social Security Number 5. Social Security Number 6. Sex 214 46 3039 Usual Residence of Decedent 10a. State 10b. County MARYLAND ALLEGANY In J. Was Decedent Ever in U.S. 11. Marital Status 1 Never Married 1 Never Marri	## As. Facility Name (if not institution, give sireet and number) As. Facility Name (if not institution, give sireet and number)	EDNA MAY HAGER 4a. Facility Name (If not institution, give street and number) Action of the product of the pr	## EDNA MAY HAGER 4a. Facility Name (if not institution, give street and number) 5. Social Security Number 6. Sex 10. Social Security Number 6. Sex 11. May 28 F	EDNA MAY HAGER 4a. Facility Name of mod instruction give street and number) 5. A.C. BERT HEP ACTION (Account) 5. Decade Security Number 6. Sex 1 1/Age (in year set methoday) 1. A.B. Chart Ham Pack (Account) 1. A.B. Chart Ham Pack (Account

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23c, detailed Maryland / Department of Health and Mental Hygiene 2 1 1 State Amend Item 25 per Me, G832,06/12/04dhb Certificate of Death Registrar 05617 2. Date of Death 1 Decedent's Name (First Middle Last) Month Day Year **Physician** 4:56 PM Donald Kevin Inskeep February 5, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Towson Under 1 Year Greater Baltimore Medical Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day Year) Sept 15, 1955 If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days Min. Hours Months 1⊠M 2□F 48 220-62-4289 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 1 Yes 2 No Westminster Director MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21157 337 Old New Windsor Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nationwide Insurance Insurance Agent 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Dottie Colerider Ken Inskeep 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 36 Fitzhugh Avenue Westminster, MD 21157 M/M Ken Inskeep/parents 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Meadow Branch Cemetery 2/9/2004 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pritts Timeral" Home and Chapel, P.A. 412 washington Road Westminster, MD 23a. Part . Enter the disease, or complic lices that caused the shock, or heart failure. List only one cause on each line. eas to t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/2/No 1 ☐ Yes 2 ☐ No Mound 1 Yes 26. Place of Death Check onlione 25. Was case referred to medical Be examiner? 1 A Yes 2 Stro Hospital: 1 Appatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

s been signed by to should be detach Records, has e 2 page certificate of Vital Director: After this I in by the funeral d Division Attending s after death. ō To the Hospitel o within 24 hours aff To the Funerel Di completely filled in

Funeral

Director

item 27 is marked other than "natural", or Items 23a or 28e-1 show other treumatic event, the Musical Exercites must be notified at

and Mental Hygie is marked other

Department of himportent: If ite Pages 1

Physician /Medical Examiner

attending physicien and for use as the burial-transit death certificate be executed Box 68760,

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> State Registrar

31. Date filed (Month, Day, Year)

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32. Registar's Signature

mpleted cause of death (Item 234) (Type, Print)

State Registrar RUBIO, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA

31. Date filed (Month

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

111 Penn Street, Baltimore, Maryland 21201

		-	State of Maryland / Department of Health and Me State of Maryland / Department of Health and Me RegistrarAmend Item#7perFHG8282/26/04 EW Certificate of Death		ene g. No. 2004	05619
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,	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	eniuai	4c. County of Death	<u>(9:20a</u>
		e.	Anne Arundel Medical Center Annapolis	8 Date of Birth	nne Arund	ace (State or Foreign
	Funeral Director		Months Days Hours Min.	(Month, Day, 2C. 11	1953 D.C	try)
	anyland show	_	10a. State 10b. County 10c. City, Town or Location		1	Od. Inside City Limits Maryes 2 □ No
	th the M or 28e-f a notifie	Director	Maryland Anne Arundel Annapolis 10f. Zip Code	10	g. Citizen of What Coun	try?
	23a (23a)	ral	19 Hicks Avenue 21401		USA	
9	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. do ther than "netural", or items 23s or 28e-f show event, the Medical Examinar must be notified at	/ Funeral I	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 12. Was Decedent of Hispanic Origin? (Specific Forces) 13. Was Decedent of Hispanic Origin? (Specific Forces) 14. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces)	cify Yes or No- tican, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.
Maryland 21215-0036	2 hours etural', cal Exa	ted by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1975 — 79	1	6b. Kind of Business/Inc	
1215	within 7, ene. than 'n he Medi	Completed	(Specify only highest grade completed) (Give kind of work done during most of workin life. DO NOT use retired) (Give kind of work done during most of workin life. DO NOT use retired)	9	110 31 - 1	
nd 2	be filed tal Hygid d other event,	Be	12th 0 Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name			Academy
yla	should be ind Mental s marked o umatic eve	၉	Robert Jamison Jr. Marjori			Codel
Mar	d 2 sh, th and 7 is m traum		19a. Informant's Name/Relationship (Type, Print) Marjorie Jamison) Mother) 19b. Mailing Address (Street and Number or Rural) 19c. Mailing Address (Street and Number or Rural)			
	is 1 and 2 should of Health and Men item 27 Is marke other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of Computer Comp		Oc. Location - City or To	
E C	⊕ o == =		Maryland Veteran 2/6/0 1 □ Donation 5 □ Other (Specify) Maryland Veteran 2/6/0	04 0	Crownsvill	e, Md.
Baltimore,	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wm. Reese & Sons 821 West St. Ann	Mortu	nary, P.A.	01
Ĺ	Medical /Medical / Itausit	Examiner	23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Industrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	respiratory arre	st.	Approximate Interval Between Onset and Death
68760,	tificate be executed by physician and as the burial-transit	cal	d			
.O. Box	The law requires that the death certifics ate has been signed by the attending plagge 2 should be detached for use as I	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delive Month	ry Day Year
rds, P.	w requires that the bean signed by should be detact	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to th s 2	
i Records,	The law requate has been page 2 shoul	Completed		24a. Was an autopsy perform 1 Yes 2	24b. Were auto prior to condeath? No 1 Yes	osy findings available inpletion of cause of 2 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: When the control of Death Other: A Description of Death Other: A Death Other: A Description of Death Other: A Description of Death O			
ō	Phys r this ral dir	- T	27. Manner of Teath 28a. Date of Injury 28b. Time of 28c. Injury at 2		nce 6 ⊡Other (<i>Specif</i>) w injury occurred	"
ion	Attending F r death. ector: After by the funeri	atior	Natural 5 Pending (Month, Day Yeer) Injury Work? Accident investigation M 1 Yes 2 No			
Division	al or Atte after de: Directo d in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Str City or Town	eet and Number or Rura , State)	l Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate the completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Cardifying Physician: To the best of my knowledge, death occurred at the time, date and place, a manner stated. Check only one)	nd due to the ca	use(s) and manner as state and place, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title at certifier 29c. License number D 5 5 1 8 7	29	Od. Date signed (Month,	Day, Year)
			30. Name and address of person completed cause of death (Item 23a) (Type, Print)	((0	nter	
	Sta Regist	ate rar	31. Date fileb (Month, Day, Year) FEB 0 5 2004 32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene 2004 05620 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year 05 2004 **Physician** RICHARD P, JOHN SON 340 PM FEB /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLUMBIA If Under 1 Year If Under 24 Hrs. HEWAKD CEUNTY GENERAL HOWARD 8. Date of Birth (Month, Day, Year)
Feb 13, 1930 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1X M 2 □ F Hours 014 22 7570 Director 73 Massachusetts Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5400 Vantage Point Road Apt 906 21044 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 1 □X/es 2 □ No
If Yes, Give
Year or Dates: 1951-82 Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Specify: "natural', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 2 1 is marked other the any injury or other traumant Colone1 Marine Corps 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Johnson Genevieve Birmingham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret T. Johnson/Wife 5400 Vantage Point Road Apt 906 Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial ② Cremation 3 ☐ Removal from State Metro Crematory 2-6-2004 Catonsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) all mo-utlly 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee Stom 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEMORREMAGIC **Physician** 1 DAY /Medical Due to (or as a consequence of): Examiner CASTRO INTESTI NAL VPPER 1 DAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transit VLCERS DAYS DUODENAL Due to (or as a consequence of): Box 68760, physician Physician/Medical as the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No o 9 Unknown 9 DUnknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, MOTERY CORUNARY 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed peen 15 CHEMIC KDWEL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 PULMONARY DISCHILYOS CHRONIC 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes 2 No 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 047897 - MD 120 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ドネルバラ CHUID IAN PATUXENT PAMEWAY COLUMBIA 072 LITTLE 32. Regetrar's Signature State Registrar

1 - State Registrar	Ce	rtificate of	Death	F	leg. No.	4 05621
1. Decedent's Name (First, Middle, Last) Physician Wesley Alexander Ja	ames			2. Date of Dea Month Feb. 1	Day Y	3. Time of Death 2205 M
/Medical Examiner 4a. Fecility Name (If not institution, give street and number) Deershead Hospital Cent	er	4b. City, Town, or Salis	Location of Death		4c. County of Wicom	
Director 239-26-3120 ★ 2□F 8	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 03/02/	, Year)	Birthplece (State or Foreign Country) I. Carolina
Usual Residence of Decedent 10a. State 10b. County Dorchester	Oc. City, Town or Lo		rlock			10d. Inside City Limits 1 ☐ Yes 2 💆 No
To be street and Number 10e. Street and Number 5035 Mt. Zion Road 11. Marital Status 12. Was Decedent Ev. Armed Forces? 1 1 New 1 1 Never Married 2 Married 1 1 Status 1 Never Married 2 Married 1 Never Named Forces?		10f. Zip Code 21	643	1	10g. Citizen of Wha	at Country?
Dorchester 10a. State MD Dorchester 10a. State MD Dorchester 10a. State MD Dorchester 10a. Street and Number 5035 Mt. Zion Road 11. Marital Status 12. Was Decedent Every Armed Forces? 1 Never Married 2 Married 12 Marged Forces? 1 Yes 2 Married 12 Married Forces? 1 Yes 2 Married 14 Married Forces? 1 Yes 2 Married 15 Yes 16 Y		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 █ No		pecify Yes or No- pecify Yes or No- pecify Yes or No-		American Indian, White, etc. Black
The state of the s	(Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work ()	king	16b. Kind of Busin	
To perform the state of the sta				e James	Maiden Sumame)	
19a. Informant's Name/Relationship (Type, Print) Wesley W. James/Son		ng Address (Street a				
20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	20b. Place of Dispo		e)	Date	20c. Location - Cit	y or Town, State
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	22	2. Name and Address	ss of Facility F	rampton	Funera	1 Home, P.A.
(Macdical resulting in death)	consequence of):		g, such as cardiac			Approximate Interval Between Onset and Death 3 WCCKS
Sequentially list conditions, if any, leading to immediate cause the dead of the cause of the ca	consequence of): SGEROTO			AR DIS	EASE	YRS
Attending of the part of the p	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day Year
Part II. Other significant conditions contributing to death but in the property of the propert	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	11	te to the cause of death? Probably 4 Unknown
Diabetes mellitus - 2 ENDSTAGE RENAL DIS 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? Which is a specific and the second of t	EASE			24a. Was a autops perform	ned? prior	e autopsy findings available to completion of cause of h? Yes 2 \(\subseteq \text{No} \)
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien	nt 3 DOA Othe	26. Place of Deat		e) ance 6 Other (Specify)
To the property of the propert	28b. Time of Injury	Work	at		ow injury occurred	
	- At home, farm, str (Specify)	eet, factory, office		28f. Location (St City or Town	reet and Number on, State)	r Rural Route Number,
the first of the position of t	kamination and/or in	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the carred at the time, da	ause(s) and manne ate and place, and	or as stated. due to the cause(s)
	lany CA	29c. License			9d. Date signed (A	
30. Name and address of person who completed cause of deal Virginia A. Dulany MD	th (Item 23a) (Type,	Print)	2018,	Salisbu	ny, Ud.	2,2004 21801

DHMH 17 Rev 1/2001

Registrar

2 2004

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Man	yland / Depa <i>Cei</i>	artment of He tificate of D	ealth and M Death	lental Hygi	ene 200	4 05622
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Robert Allen J	ester				2. Date of Death Month Feb.	3, 2004	0745 ^M
	Examir	er	4a. Facility Name (If not institution, give s 6050 Dion Road 5. Social Security Number 6. Sex		In yrs. last birthday)	4b. City, Town, or L Federa If Under 1 Year		8. Date of Birth	4c. County of De	ne
N ₂	Funeral Director		214-42-8207 TS]M 2□F	62 Yrs.	Months Days	Hours Min.	Feb.6,1	941 Mai	irthplace (State or Foreign Sountry) ryland
	e Marylar Be-f show	Director	MD 10b. County Caroli		Oc. City, Town or Lo		alsburg			10d. Inside City Limits 1 ☐ Yes X ■ No
	s 23a or 2 rust be no		10e. Street and Number 6050 Dion Road				1632	U	g. Citizen of What C	tates
036	ours after de al', or Item Examine D	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent of His f Yes, specify Cuban i ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28s-f show any injury or other traumatic event, If a Medical Evaninar must be notified at ODGe.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation o completed) College (1-4or 5+)	(Give	lent's Usual Occupat kind of work done du DO NOT use retired) I C T		ing	Roultry	s/Industry /Produce
/land	uld be file Mental Hyg irked otha	To Be C	17. Father's Name (First, Middle, Last) Robert H. Jest	er		1		sephine	Anthon	y
, Mar	and 2 sho ealth and in 27 is ma	6 S	19a. Informant's Name/Relationship (Ty) Sharon J. Jest	er/Spous	e 6050	g Address (Street and Dion Ro	d., Fed	eralsbu	rg, MD	21632
timore	Pages 1 Iment of Hi tant: If iter jury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from State	Bloomer	y Cemete	ery2/6/	04 F	oc. Location - City o	burg, MD
Bal	permit Depar Impor any in		21. Signature of Funeral Service License	Eskow	2	216 N. Ma	ain St.	, Feder	alsburg	Home,P.A. , MD 21632
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a c	onsequence of):	en Mue	such as cardiac c	or respiratory arres	it,	Approximate Injerval Between
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
P.O. Box 6	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 Live birth 2 [4 Pregnant at tim 9 Unknown	Fetel death 3	Ectopic pregnancy Other (specify)	**		23d. Date of de Month	Nivery Day Year
rds, F	w requires the been signed should be de	by	Part II. Other significant conditions con	tributing to death but n	ot resulting in the un	derlying cause given	in Part I.	23e. Did toba 1 ☐ Yes	/	o the cause of death? robably 4 Unknown
Division of Vital Records,	: The law recate has be page 2 sho	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of s 2 No
Ž	alciar certif irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2 ER/Outpatient	Other		(Check only one)		-
ion of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injury a Work?		me 5 Resident 28d. Describe how		ecity)
Divis	ital or Attendeathrs after deathral Diractor:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	Specify)			City or Town,	,	
	To the Hospital within 24 hours To tha Funaral completely filled	Medical	one)	ician: To the best of more: On the basis of exand manner stated	amination and/or inv	occurred at the time, estigation, in my opin	, date and place, a nion, death occurre	and due to the cau ed at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
)	To the within To the Comple	2	29b. Signature and title of certifier Wear	m-		29e License	7887	290	Date signed (Mont	th, Day, Year)
			David Smith, M	mpleted cause of death	e Pintail	Drive-Su	ite 5,	Easton	, MD 21	WU
73	Sta Registr		31. Date filed (Month, Day, Year) FEB 4 2004	32. Registrar's	Signature	521				

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 05623 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0700 - M February 2004 14, Jackson Mary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisbury Anchorage Nursing Home Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax **Funeral** 1 □ M 2 😿 F Maryland 82 Director 218-20-7099 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location wode 10a. State 10b. County r than "natural", or Items 23a or 28a-f ehov the Modical Examiner must be notified at 1 Yes 2 No Director Princess Anne MD Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 27810 Mt. Vernon Road 21853 Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after v v and Mental Hygiene. is marked other than "natural" or Iter 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 þ 3√ Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Important: If item 27 is marked other tt eny injury or other traumatic event, this once. 10 none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Hearne George L. Beauchamp, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn June Bell/Daughter 4785 Cardinal Drive, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Asbury U.M. Cemetery | 02-17-2004 | Mount Vernon, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hinman Funeral Home 22a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 111673 Somerset Avenue, Princess Anne, MD 21853 Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** ASPIRATION 5days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Syrans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ASWI The law requires that the death certificate be executed 54 cons that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed2 certificate ! 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No ၉ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: the Hospitel or Attending 1 Natural 5 Pending after death.

Diractor: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel L to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie work February 15/1 2004 0057359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. rohm 1415 SALISBURY 7021804 .S. DIVISION 57 32 egistrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 3 2004 Sellen . Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05624 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 13, A^{M} Jones 2004 0132 Linnie /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Sep 8, 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1915 1 □ M 2 □ XF Yrs 278-22-8451 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show e how Allegany Cumberland 1 TyYes 2 □ No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r items 23a or 2 21502 USA 1206 LaFayette Avenue Completed by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No ö Specify: white Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced "natural" er than "nature". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 le marked other than other traumatic event, Item Laborer Celanese Corp. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Maude Phillips John Phillips ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21502 1206 LaFayette Avenue Cumberland daughter Diane Cain 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: if Ite any injury or ot once. 1 Dourial 2 Cremation 3 Removal from State 2/16/2004 MD Cumberland * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Albane, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 sunno 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CEREBRALVASCULAR ACCIDENT 3 DAYS Physician resulting in death) /Medical Due to (or as a consequence of): Examiner MYOCARDIAL INFARCTION 3 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. I 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2∏ No 2 🖾 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the lest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and magner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Fe m D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. POONAI, M.D. 924 SETON DRIVE CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature and to freeze Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Mar	yland / Depa <i>Cei</i>	artment of F	lealth and N Death	lental Hyg	iene 200L	05625
	Discortati		1. Decedent's Name (First, Middle, Las	et)				2. Date of Dear	th Day Year	3. Time of Death
	Physicia /Medic		Albert B. Kaltw	asser				Februa:		11:56 P™
F	Examin		4a. Facility Name (If not institution, give				or Location of Death		4c. County of Deat	
			Anne Arundel Med			Annapo		T =	Anne Aru	
	Funeral		5. Social Security Number 6. So	D	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Dec • 24	Year) 9. Birtl	nplace (State or Foreign untry)
	Director		339-14-1302 Usual Residence of Decedent	X ^M ² 85) ''''			Dec. Z	4, 1918 Mi	ssouri
	and		10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits
	f sho	ō	Maryland Anne Ar	undol	Annapo	lic				1 ☐ Yes 2 🛣 No
	1588.	Je C	10e. Street and Number	under	minapo.	10f. Zip Code		1	0g. Citizen of What Co	untry?
	3a or	0	1213 River Cresce	nt Drive		214	01		USA	
	death	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
9	after or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	+	1 ☐ Yes 2 🛣 No		rticali, etc.)	Black, White	hite
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2-(within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28a-f show the Mcdical Exandrier institut and	Completed by	15. Decedent's Ed (Specify only highest gra	lucation de co <i>mpleted)</i>	16a. Dece	dent's Usual Occup kind of work done	pation during most of work d)	ting	16b. Kind of Business/	Industry
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2	filed withii Hygiene. other than ent, the M		17. Father's Name (First, Middle, Last)	4 years	VICE	e rieside		e (First, Middle, I	Maiden Sumame)	illium Co.
anc	od o	Be		Kaltwasser	2			oline Be		
Ž	should and Men amarke umatic	P.	19a. Informant's Name/Relationship (na Address (Street			, City or Town, State, 2	Tip Code)
Maryland 21215-0036	1 and 2 should be filed withir Health and Mental Hygiene. Iem 27 is marked other than other treumatic event, the My		Dorothy A. Kaltwa						polis, MD 2	
	1 and Health tem 27 other tr		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	1	Date	20c. Location - City or	Town, State
OL O	Pages nent of I nnt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		•	matory or other place rematory	2-14	-04	Edgewater,	Marvland
Baltimore,			21. Signature of Funeral Service Licen				1		Kalas Fune	
Ba	permit. Departr Importe eny inji		> Mout P. Can	as	2	2973 Solo	mons Isla	and Rd. I	Edgewater,	MD 21037
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused th one cause on each line.						Approximate Interval Between Onset and Death
7	Physician		Immediate Cause (Final disease or condition	a	0/	rome				2 days
	/Medical Examiner		resulting in death)	Due to (or as a o	consequence of):	•				
	LAGIIIIIO	_	Sequentially list conditions,	b. Due to (or as a	consequence of):					
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687		_		d						
Вох	nding use	Z/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		75-1			23d. Date of deli	very
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin		∃Ectopic pregnancy ∃ Other (specify) _	у		Month	Day Year
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ord	equir en si ould	ted						1 🗆 Ye	es 2 2 No 3 Pro	obably 4 Unknown
Records,	lawr as be	Completed			 .			24a. Was a autops	sy / prior to d	topsy findings available completion of cause of
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Vital	ding Physicien: The lav h. After this certificate has funeral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Dear	h (Check only on	le)	
of	Physi this c al dire	၉	1 Yes 2 No	1 Lympatient	2 ER/Outpatie	nt 3 DOA	4 U Nursing Ho		ence 6 Other (Spec	cify)
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isic	Attending r death. ector: After by the funer	icat	2 Accident investigation 3 Suicide 6 Could not b	e Diego of Injury	/ - At home, farm, st		,,,,,,	28f. Location (St	treet and Number or Ru	ral Route Number.
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	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	(Check only 2 Medical Exar	ysician: To the best of e	xamination and/or in	h occurred at the til	me, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	thin 2 thin 2 the I	Med	29b. Signature and title of ceptifier	and manner state	u.	29c. Licens	se number	2	9d. Date signed (Mont)	n, Day, Year)
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			30. Name and address of person who	Ten 6	OC RIU	16/V A	Ve H	nning	b, MD	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature		• • • • • • • • • • • • • • • • • • • •	· · · · · · · ·	, , , , , , , , , , , , , , , , , , , ,	
	Regist	rar	FEB 1 1 2	UU4	10 15 A					

State of Maryland / Department of Health and Mental Hygiene 2004 05626 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 1:20 p M 4, 2004 February Anna Josephine Keyes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Carroll Westminster 115 W. Main St. Apt. 1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Days 1 ☐ M 2 🔀 F 81 Maryland Director 213-72-0214 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "naturat", or tems 23s or 28s-f show any injury or other traumatic event. It is Medical Examination in the notified at once. 1 XYes 2 No Carroll Westminster Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21157 Apt. 1 115 W. Main St. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: à White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marie Wright Albert Godfrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 641 North Bend Rd., Baltimore, MD 21229 Roseanne St. Clair/Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation Inc. 02/05/2004 Hampstead, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Pritts Funeral Home & Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Oncet and Death Metas: Immediate Cause (Final Chy **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Iding physician and resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗹 No be detached Ö 9 Unknown 9 Unknown ģ م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation after death.

Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medica Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner related. 29a. Certifier Medical 29d. Date signed (Month Day, Year) 29b. Signature and title of certification 29c. License number Mille WIL 30. Name and address of person who completed cruse of death (Item 23a) (Type, Print) 0 LUTO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 05627 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician LENORE KENNEDY FEB. 4, 2004 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINSTER CARROLL HOSPITAL CENTER Carroll 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🖔 F 99 Yrs. Director 115-32-3217 6,1904 PENNSYLVANIA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Examinar must be mailfied at 1 XYes 2 ☐ No GETTYSBURG Director PA. **ADAMS** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 301 STEINWEHR AVE. 17325 USA death v 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No SpecifyWHITE þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKER 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 1s marked othe any injury or other traumatic event, 900s. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) NINA HARRY GILBERT WOOLHEATER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH KENNEDY SON P.O. BOX 486, MILLBROOK, N.Y. 12545 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 X Removal from State 2/9/04 ST. JOSEPH CEM. MILLBROOK, N.Y. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME 21. Signature of Funeral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD. Jan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus 1 on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Demenna /Medical Due to (or as a consequence of): Examiner Deplession Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a consequence of 日出り death certificate be executed Exam and Due to (or as a consequence of): physician a poalburning Physician/Medical as the attending IF FFMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe þ 3 ☐ Probably 4 ☐ Hiknown 1 TYes 2 □ No Completed ecilb ithis 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page certificate 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 2 ER/Outpatient 3 DOA this (27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending 1 Natural 5 Pending Injury after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours after To the Funeral Dire cal 29a. Certifier i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of 1-0054218 104 WJZ 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Lamen & Kanery 34 Malcain, duk, himself, MD 3 31. Date filed (Month, Day, Year) 32. Registrar's Signature Gleen Is Speed Registrar

ORIGINAL

		State of Maryland	I / Depa	artment of H	ealth and I Death	Mental Hy	giene 200	4 05628
Physici /Medic		1. Decedent's Neme (First, Middle, Last) Elizabeth Mary Kanauer					ary 1,200	4 12:20A M
Examir	ner	4a. Facility Name (If not institution, give street and number) Crofton Convalescent Center 5. Social Security Number 6. Sex 7. Age (In yrs. la	ist birthday) Yrs.	4b. City, Town, or Croftc If Under 1 Year Months Days			Anne Aru	ndel httplace (State or Foreign country)
Director services	tor		Town or Lo	ocation Onville		April	2,1921 Wa	shington, DC 10d. Inside City Limits 1 Yes 2 XNo
with the	Direc	10e. Street and Number 3518 Russell Thomas Lane		10f. Zip Code	1035		10g. Citizen of What C	Country?
Datifiliofe, Intal yielding ZIZIO-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itams 23e or 28e-f show importants of items 25e or 28e-f show principly or other traumatic event, it is Micalcal Event, is a marked at 1000ce.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 Never Married 2 Married 11 Yes 2 No If Yes, Give Year or Dates:	í	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		ite, etc.
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should be filed and Mental Hyg	To Be C	17. Father's Name (First, Middle, Last) Joseph Warren Krahling 19a. Informant's Name/Relationship (Type, Print)	19b. Maili		Elizab	eth Mary	Maiden Sumame) Nutter or, City or Town, State,	Zip Code)
Te, Ma		M. Suzanne Thrift/ Daughter 20a. Method of Disposition 20b. Pla	3518		Thomas		vidsonville 20c. Location - City o	MD 21035
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Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the condition of						Approximate Interval Between Onset and Death Yeung The arms.
te be executed ysicien and te burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due-to or as a consequence of the consequenc		rd (cur	MOVUS	cular	Disterse	Jeans
VITAL MECONOS, P.O. BOX 00/00, sician: The law requires that the death certificate be executed certificate has been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	l blivery Day Year
wrequires that wrequires that been signed b	þ	Part II. Other significant conditions contributing to death but not result Abdom wal Aortic a	-	, ,	_		obacco use contribute ves 2 ⊠No 3 ☐ F	to the cause of death? Probably 4 □Unknown
ar neco	Completed			,			prior to rmed? death? 2 No 1 Ye	utopsy findings available completion of cause of
Phys This	ation; To Be		ER/Outpatier 28b. Time o Injury	of 28c. Injury Work	er: Nursing H		ne) dence 6 Other (Sp. now injury occurred	ecify)
To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, str	reet, factory, office		28f. Location (S City or Tox	Street and Number or F vn, State)	lural Route Number,
ne Hospil n 24 hour ne Funera	Medical	29a. Certifier (Check only one) 10 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinati and manner stated.	rledge, deat on and/or in	h occurred at the time evestigation, in my op	ne, date and place pinion, death occu	e, and due to the corred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
Totl withii Totl	M	29b. Signature and title of certifier A Kesh Mag	mi	29c. License			29d. Date signed (Mor	
		30. Name and address of person who completed cause of death (Item Rakesh Arora, M.D. 14300 Galla	ant Fo		ite 222,	Bowie,	MD 20715	/
St. Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 3 2004 32. Registrar's Signate	A A	book		,		

State of Maryland / Department of Health and Mental Hygiene 2004 05629 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 3, 1:45 P M **Physician** 2004 Nancy Cookson Kimmel
4a. Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Ginger Cove Health Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🔀 F Director Apr. 6, 1919 Sumatra 231–62–9112 84 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f ehow Examiner must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4000 River Crescent Drive 21401 U.S.A. 238 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Marned ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) Travel/Entertainment Tour Guide permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 ie marked other It any injury or other treumatic event, Illis once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Stanley Cookson Bernice Dunlap Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) William Kimmel/son 2908 Winters Chase Way Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Baltimore Crematory 2/5/2004 Baltimore, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Semice binnsee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 lectre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) sementic **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): use as the burial-Division of Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Į 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed? 2 - No 1 ☐ Yes 2 -NO 1 🗌 Yes or Attending Physician: ector. 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the 1 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide Hospitel 1 <mark>ビ Certifying Physician:</mark> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the h 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 24768 2-4-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William Dabbs, M.D. 277 Peninsula Farm Rd. Arnold, MD 21012 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6, Hilda Cole Kelley Feb. 2004 1640 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Huder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Mar. | 19,1913 Annapolis Anne Arundel Birthplece (State or Foreign Country) 5. Social Security Number 6 Say 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 217-09-1022 90 MD Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or itams 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Anne Arundel Director Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 Giddings Avenue 21146 USA Completed by Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 le marked other then "natural", or Ital eny injury or other fraumatic average. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unavailable Unavailable 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DuAnne C. Chrisman/Daughter 202 Giddings Avenue, Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 11, 20a. Method of Disposition 20c. Location - City or Town, State Feb. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery Brooklyn, *4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Euperal Service Licenses 495 Gov. Ritchie Hwy. Severna Park, nons MD 21146 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) & years /Medical Due to (or as a cons Examiner ers CONDIONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pg 2 **X**No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy certificate 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 XI patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral of 27. Manner of Death 1 XNatural 2 Accident 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donna Chamber MD 31. Date filed (Month, Day, Year) State Registrar

	- ,	•	1 - For State of Maryland / Departm	nent of Health and M cate of Death	ental Hygier	- ZUU4 U5631
	Physicia		1. Decedent's Name (First, Middle, Last)			3. Time of Death
	/Medic	al	CATHERINE HARRINGTON KEMPER 4a. Facility Name (If not institution, give street and number) 4b.	City, Town, or Location of Death	FEB.17,2	2004 6:00 A *** 4c. County of Death
	Examin	er	CHARLES CO.NURSING & REHAB CENTER			CHARLES
	Funeral Director		5 Social Security Number 6, Sex 7, Age (In yrs. last birthday) If L	Index 1 Veer If Under 24 Hrs	8. Date of Birth (Month, Day, Yea VOV • 9 , 19	O. Birth-less (Ctate or Foreign
bu	100		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n		10d. Inside City Limits
Mary	r 28a-f show	tor	MARYLAND CHARLES	LA PLATA		XXYes 2 □ No
4	or 28a	lrec		Of, Zip Code	10g. (Citizen of What Country?
the character and the	23a	rai	10200 LA PLATA ROAD	20646	noity Van ar Na	U • S • A •
72 hours after death with the Maryland	, or Items	by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2127 No	Decedent of Hispanic Origin? (Spe i, specify Cuban, Mexican, Puerto res 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: WHITE
P of	atural		15, Decedent's Education 16a. Decedent's	S Usual Occupation of work done during most of worki	16b.	. Kind of Business/Industry
		Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO N	IOT use retired)		DDD0 0000/ 0011 EGE
filed within	the tr		12 2 ADMINI 17. Father's Name (First, Middle, Last)	STRATIVE ASS' 18. Mother's Name	LA LA (First, Middle, Maid	REDO COMM • COLLEGE den Sumame)
1	S d al	То Ве	TIMOTHY O'CONNOR	MARY	DILLON	
o charle	and is m			Idress (Street and Number or Rura		
1	Health tem 27 i		CATHERINE JENSEN-DAUGHTER 201 SP			LATA, MD. 20646 Location - City or Town, State
	ayes and of the first the		1 ☐ Burial 2V Cremation 3 ☐ Removal from State	y or other place)		EXANDRIA, VIRGINIA
	Department of Personal Industrial		21. Signature of Funeral Service Licensee MOO479 22. Nar RA	me and Address of Facility YMOND FUNERA	L SERVIC	E,P.A.
	10 = % G		23a, Part 1. Enter the disease, or complications that cau led the death. Do not enter the	PLATA, MARYLA e mode of dying, such as cardiac	AND 2064 or respiratory arrest,	Approximate Interval Between
P	hysician		shock, or near failure. List only one cause on secondine.	Heart Fail		Onset and Death
	/Medical	Н	resulting in death) Due to (or a set consequence of):	12411 1-41	474	
	xaminer	_	Sequentially list conditions, b. Due to (or as a consequence of):			
	died di ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
5	be executed ician and burial-transit		resulting in death) Last Due to (or as a consequence of):			
		dlcai	d			
YOU	w requires that the death certifies been signed by the attending pt should be detached for use as t	Physician/Med		ppic pregnancy		23d. Date of delivery Month Day Year
5	ribe desi	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Oth	ner (specify)		
Ĺ	ned by deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
cords,	equires en sig culd bluc				1 ☐ Yes	2 o 3 Probably 4 Unknown
ב בכנ	the lar	Completed			24a. Was an autopsy performed	
N 2	cien: ertifica ector,	Be	25. Was case referred to medical examiner?	26. Place of Death	P.O. T. A. C.	
5	Physi rthis c ral dir	. To	1 Yes 2 No No No No No No No	BL DOA 4 Nursing Ho	me 5 Residence 28d. Describe how in	e 6 Other (Specify) njury occurred
VISION	nding th. ;: Afte	ation		Work? I Yes 2 No		
DIVIS	To the Hospitel or Attending Priysicien: within 24 hours after death. To the Funeral Director, After this certifica completely filled in by the funeral director, it	ertification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
:	Mospite 24 hours 5 Funera etely fille	dicai C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurrence of examination and/or investigated.	curred at the time, date and place, gation, in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the To the compl	Me	29b. Signature and title of certifier	29c. License number 000 5 2919	29d.	Date signed (Month, Day, Year)
	b		30. Name and address of person who completed cause of death (Item 23a) (Type, Print	t)	-aplata	MD 20646
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	france :	-7/17/9	7.10 0/16
	Regist		FEB 2 3 2004 Januar 15	frances .		

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth **Physician** Year February 07, 2004 cation of Deeth 4c. County of Death Estalene Belle Knight 8:00 p.m. /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner 267 West Main Street Washington Hancock If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2**X**F Yrs Director 80 213-20-9436 August 10,1923 Usuel Residence of Decedent Pagas 1 and 2 should be filed within 72 hours after death with the Meryland nant of Health and Mentel Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "naturel", or tems 23a or 28e-1 show other traumatic event, the Medical Examiner must be notitied at 1 TYPY 2 □ No **Funeral Director** Washington Hancock 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 267 West Main Street 21750 USA 12. Wes Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify Š 3 Widowed 4 □ Divorced White Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Manufacture Depertment of Health and Mentel Himportant: if item 27 is merked of hany injury or other traumatic event once. 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Harry Hoyle Mary Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Lynn Knight/Daughter 267 West Main Street Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Tonoloway Baptist 02/11/04 Needmore, PA 21. Signature of Fune of Salvier Licens 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical week Examiner Due to (or as a consequence of): Physician/Medical Examiner 50 or Attending Physician: The law requires that tha daath certificeta ba executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of). Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Be Completed by 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: After th completaly filled in by the funerel 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Maturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🚅 rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) cass 111 31. Date filed (Month, Day, Year) 32. Registrer's Signature State FEB 23 2004 Registrar Grocks

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2004 05633 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 02 **Physician** BERTHAM. LEE 9:22 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Hunder 1 Year If Under 24 Hrs. Arundel Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year) Oct. 22, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F 89 Yrs. 1914 Maryland Director 215-05-4766 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 21/21No Maryland Anne Arundel Annapolis Directo 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code tems 23a or 3023-B Arundel on the Bay Road 21403 U.S.A. Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3X Vidowed 4 ☐ Divorced naturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If item 27 is marked other It
any injury or other traumatic event, Ita
once. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Germuth Elizabeth Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Egendorf/daughter P.O. Box 713 Lincoln MA 01773 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial

☐ Burial

☐ Removal from State Baltimore Crematory 2/10/2004 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signatur neral Stryice Licensee 147 Duke of Gloucester Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bowe Necrotic Physician /Medical Examiner Atherosclerosi Years if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit sicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending phys the th IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Mo
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ed bluods Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has 1 ☐ Yes After this certification funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 100 1 N patient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Daath 28b. Time of 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funerel Director: A investigation the 1 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Fune completely fi (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2/6/04 1. broshe D56357 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2002 MEDICAL PARKWAY SUITE 360 ANNAPORIS, MD 21401 AROSHAN, MD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

FEB 1 1 2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05634 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer **Physician** Muriel Gladys Lefferts 08:55 AM 4b. City, Town, or Location of Death 31 2004 /Medical 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Sunbridge Care Elkton Ceci1 If Under 24 Hrs. 8. Date of Birth (Month, Dey, 3-13-1 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) **Funeral** Days Months 1 □ M 2 □ xF 79 Yrs 221-14-1530 PA Director Usuel Residence of Decedent реттіt. Peges 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mentel Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or itema 23s or 28e-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Delaware Kent Director Wyoming 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 18 W. Peach Street 19934 USA 11. Meritel Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2½ No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Secretary 12 Insurance Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond S. Failing, Sr. Euphemia Orvis 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Wendy L. Sapp/Daughter 224 Waterford Dr., Middletown, DE 19709 Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Feb.5 Odd Fellows Cemetery Camden, DE 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Neme end Address of Fecility 21, Signature of Funeral Service Licenses Pippin Funeral Home 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. 119 W. Camden-Wyoming Ave. Wyoming, DE19934 Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Sepsis Examiner Physician/Medical Examine cho ettending physician and for use as tha bunal-transit 14m The law requires that the death certificeta be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): certificate has been signed by the elirector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco uee contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes cese referred to medical exeminer? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No ဥ After this 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Deeth 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. edical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifie DOO 35779 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 251 S. Bo hemia Ave, Lecillon Md. 21913 Obens M.D. hain W. Bruce 31. Dete filed (Month, Day, Year) 32. Registrer's Signature

Registrar **DHMH 16 Rev 6/95**

State

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Н	Physici	an	1. Decedent's Name (First, Middle, Las	•						2. Date of De		ay Yea	ar I	3. Time o	
	/Medio		Anthony Wade La							02	14	0	4	12:	55 PM
	Examir	ner	4a. Facility Name (If not institution, give	•			_	Location of	of Death			c. County of D			
			3528 National Pi 5. Social Security Number 6. Se		(In yrs. last birthday		COCK	If Under:	24 Hrs.	8. Date of Bir		lashing		Canal	ou Cousien
	Funeral Director			M 2□F	36 Yrs.	Months		Hours	Min.	(Month, Da	ay, Year	7	Counti	y)	or Foreign
			Usual Residence of Decedent							November	21,	1967 M	D		
	nylan show	_	10a. State 10b. County		10c. City, Town or L	ocation							10	d. Inside C	
	Ba-f s	Director	MD Washingt	on	Hancock										s 2√∑ No
	with th	F	10e. Street and Number				Code					itizen of What	Count	ry?	
	s 23	erai	3528 National P	ike 12. Was Decedent E	ver in U.S. 13.		750	enanie Orie	ain? (Sno	oifu Voc or No	US	14. Race - A	marica	n Indian	
' 0	ours after death with the Marylan 'el', or Items 23a or 28a-f show Examiner must be notified at	Funeral	1 ☑ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No)			n, Mexican	, Puerto F	cify Yes or No Rican, etc.)	_	Black, W			
93	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show ilical Examinet must be natified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗌 Yeş	2 ∏ No	Specify:				Specify:	Wh	ite	
21215-0036	d within 72 hours piene r than "natural", Ite Medical Exa	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	edent's Usu e kind of wo DO NOT u	al Occupa	ition Tu <i>rina m</i> ost	of workir	na	16b. l	Kind of Busine	ss/Indu	ıstry	
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5			12 17. Father's Name (First, Middle, Last)		Disa	bled		18 Mothe	r's Name	(First, Middle		ne n Sumama)			
and	ed ala	To Be	Donald B. Lande	rc						M. Cris		Odinamoj			
Maryland	2 should to and Ment Is marked	1	19a. Informant's Name/Relationship (7		19b. Mail	ing Address	(Street a					or Town, State	a, Zip (Code)	
	s 1 and 2 should f Health and Men itam 27 Is marke other traumatic		Donald B.Landers/	Father	3528	Nati	ona1	Pike	Hand	cock M	21	750			
altimore,	es 1 a of He fitam r othe		20a. Method of Disposition 1)∑ Burial 2 ☐ Cremation 3 ☐	Domoual from State	20b. Place of Disp cemetery, cre	osition (Nat	me of			ate		ocation - City	or Tow	n, State	
Ĕ	Pages ment of ant: If it ury or o		'4 □ Donation 5 □ Other (Specify		Mt.Olive	t Pre	sbyte	erian	02/1	7/04	Han	cock,M)		
Balt	permit. Pages Department of Important: If is any injury or once.		21. Signatury of Euneral Service Licens	C 0.	2	2. Name ar	nd Addres	s of Facility	У	14	.1 W	est Ma	in S	Stree	et
	0 □ = e 0		(Luch	Vicer								ck,MD.			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each line		0			O-		rrest,		- 1	Approxima nterval Be Onset and	tween
	Pnysician /Medical		disease or condition resulting in death)	a Carau		lme	nau	y a	tre	st			_	12	Ma
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90,	sate be executed physician and the burial-transit		resulting in death) Last	Due to (or a	consequence of):										
8760,	cate b	edicai	•	d									-		
9 x	death certifica e attending phi d for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	f pregnancy				·			23d. Date of c	loliven	,	
Box	death e atter	Physician/M	in the past 12 months?	1□Live birth 2 4□Pregnant at ti		⊒Ectopic pi ⊒ Other <i>(sp</i>						Month			Year
P.O.	that the d ed by the detached	hys	9 Unknown	9∐ Unknown							_,				
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significent conditions co	ntributing to death but	not resulting in the u	underlying o	ause give	n in Part I.		23e. Did t		use contribute			
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o	Phys er this eral di	7: To	27. Manner of Ceath	1 ☐ Inpatient	28b. Time o	3. T	8c. Injury Work	4 🗀 Nui	rsing Hom 2	8d. Describ <i>e</i> I		6 □Other (Sp iry occurred	ecify)		
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Division of Vital Records,	l or Attano after death Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory	, office		2	8f. Location (S City or Tox		nd Number or i	Rural I	Route Nun	nber,
ō	ital or irs afte rat Dir led in l			, , , , , , , , , , , , , , , , , , , ,											
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exem	rsicien: To the best of iner: On the basis of e and manner state	xamination and/or in	th occurred evestigation	at the time , in my op	e, date and inion, deat	i place, a h occurre	nd due to the d at the time,	cause(s date an) and manner : d place, and di	as stat ue to tl	ed. he cause(s	s)
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	12		30. Name and address of person who c		1.14		000	201	<i>y</i> 1	,	64	, 0			
_			Bruce E. Weneck,	M.D. 303 W	est Memor	ial B	lvd.F	lagers	stowr	n,MD 21	740				
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			1 - For State Registrar	of Marylan	d / Depa <i>Cer</i>	artment <i>tificate</i>	of H	ealth an Death	d Mental I	Hygien	e 20	04	05638
	Physici /Medi		1. Decedent's Name (First, Middle, Last)		m	TCH	- L	٤	2. Date o Month	f Death	ay	Yeer	3. Time of Death
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	Funeral Director		$\begin{array}{cccccccccccccccccccccccccccccccccccc$	7. Age (In yrs. 72	Yrs.	If Under 1 Months	Days	Hours I	Min. 8. Date of (Month)	Birth , <i>Day</i> , Yea 10–19	31	9. Birthp Coun Nort	lace (State or Foreign try) h Carolina
	ith the Maryland or 28a-f show	Director	Maryland Anne Arunde		y, Town or Lo	Rive				10g. C	itizen of W		0d. Inside City Limits 1 □ Yes 2 ☒ No
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If it lem 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 1 Yes	ecedent Ever in U. Forces? es 2 17 No Give A r Dates:	1	_1		spanic Origin' n, Mexican, P Specify:	? (Specify Yes o uerto Rican, etc.			, White,	an Indian, etc. ack
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	1 and 2 sh Health and em 27 is m ther traum		19a. Informant's Name/Relationship (Type, Print) Clyde Mitchell/ Husbar 20a. Method of Disposition			Cherr	у Р		d., West	Rive	er. M	207	778
Baltimore,	F F F		1	m State Co	ometery, ciem Vetera	ans Ce	er place emet	ery 2-	13-04	Che	ocation - C	ıam,	MD
Ba	permit. Departn Imports any inju		23a. Part 1. Enter the disease, or complications th	at caused the deeth	29	3/3 Sc)\Lom	ons Is	George Fland Rd.	Edge	las Fu ewater	nera	1 Home 21037 Approximate
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Division of Vi	his I di	Certification; To Bo	examiner? 1 Yes 2 No Hospital: 1 27. Manner of Death 1 Natural 5 Pending (M 2 Accident investigation	te of Injury onth, Day Year)	ER/Outpatient 28b. Time of Injury	280 M	Other Injury a Work?	4 🗆 Nursing	Death (Check onling Home 5 ☐ Re 28d. Describ	esidence	6 Other	(Specify)	
DIV	ospital or At hours after o unerel Direc ly filled in by		4 Homicide determined 286. Pt	ce of Injury - At hor Iding, etc. (Specify, the best of my know	viedge death	occurred at	the time	, date and pla	City or	Town, State	e)		Route Number,
·	To the H within 24 To the Fi completel	Medical	2 Medical Examinate: On the	anner stated.	on and/or inve	29c. L	i my opir icense i	nion, death or number	ccurred at the tim	e, date and 29d. Da	te signed (i	d due to t	he cause(s) ay, Year)
			30. Name and address of person who completed ca Anthony M. Caputo, M.D			rint)		nd Rd	, Annapo		,		2004
Too	Sta Registra			Registrar's Signatu	11.0			iiu I\U.	, Alliapo	JIIS,	TID Z.	1401	

			1- State of Maryland / Depa	irtment of Health and I tificate of Death	Mental Hygie		05637
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Carolyn Ann Michael		February	1 2004	7:00 A ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death	
			37 W. Broadway	Union Bridge If Under 1 Year If Under 24 Hrs.	O Data of Bigh	Carroll	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 XF 7. Age (In yrs. last birthday) 56 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y NOV 8 , 1	ear) 9. Birthp	lace (State or Foreign stry) Sylvania
	Director		201-36-5437		1107. 0,	717 10111	1371741114
	yland now		10a. State 10b. County 10c. City, Town or Lo	cation		1	0d. Inside City Limits
	Mar.	tor	MD Carroll Union Br	idge			1 X Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	itry?
	ath w	rail	37 W. Broadway	21791		U.S.A.	
	er de:	Funeral	Armed Forces?	Vas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
3	rs aft	by F	1 Never Married 2 Married 1 Yes 2 M No If Yes, Give 9 Year or Dates:	I ☐ Yes 2 ☒ No Specify:		Specify: Wh	nite
3	atura cal E	led 1	15. Decedent's Education 16a. Deced	dent's Usual Occupation		b. Kind of Business/Inc	
2	hin 72	pie	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of wo DO NOT use retired)			
7	d with	Completed	12 5+ Teac	her	F	Public scho	ols
2	al Hy al Hy 1 oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nar	me (First, Middle, Ma	iden Sumame)	
<u>x</u>	Men Men arke	ို	Warren E. Kay		ine Otto		
2	l 2 sh and is m			ng Address <i>(Street and Number or Ri</i> 1. Broadway, Unio			Code)
ב ט	1 and Health Bm 27 ther t		20a. Method of Disposition 20b. Place of Dispo			c. Location - City or To	wn. Slate
5	ages nt of l t: If it		1√ Burial 2 Cremation 3 Removal from State cemetery, crem	natory or other place)		. Union Br	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If time 72 is marked other than "natural" or items 23a or 28a-f show any injury or other treumatic event, the Macical Examiner must be multired at page.			. Name and Address of Facility H			
ם	Depi Impo			E. Broadway, Un			
			23a. Part1. Enter the disease, or complications that daysed the death. Do not ent- shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardia	or respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition) Kail	wo		Orset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):				() ()
	Examiner		Sequentially list conditions, b. Sequentially list conditions,	ON NC	RM	4	LUVJ
	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury				,
	and and I-tran	хаш	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
000	cate be executed physician and the burial-transit						
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4	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	15		23d. Date of delive	ery
ā	death e atte	icia	in the past 12 months? 1 Vas 2 Pkg 4 Pregnant at time of death 5	Ectopic pregnancy] Other (s <i>pecify)</i>		Month	Day Year
5	at the by th tache	Physician/Me	9 Unknown				
ń	The law requires that the death certific Ite has been signed by the atlending p age 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		cco use contribute to the	ably 4 Unknown
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E	: The					No 1 ☐ Yes	2 □ No
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5	Phys r this rai di	1. To	1 Yes 2 No	t 30 box 40 Adising F	28d. Describe how	be 6 Other (Specify injury occurred	/)
noision	th. : Afte	tion	1 Actident 5 Pending (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
<u> </u>	Atter	iffice	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura	I Route Number,
5	tel or	Certification;	Dallarity, etc. (openly)				
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	cai	29a. Certifier (Check only Certifying Physicien: To the best of my knowledge, death	n occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the causured at the time, date	se(s) and manner as st and place, and due to	ated. > the cause(s)
	the hin 2, the h	Medi	one) and manner stated. 29b. Signature and title of carifier	29c License number	29d	. Date signed (Month)	Day, Year
	5 × 5 8		South the state of	1020320) (holo	24
	1452		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) -	ILANICA V	nanian	/
	10		30. Name and address of person wito completed cause of death (tem 23a) type,	Mount	JUN UY VI	M15 2	191
	Sta	ate	31. Date filed (Month, Day, Year) 32. Regisfar's Signature				
	Registi		FEB 0 5 2004 Steeler St	Bosile			

State of Maryland / Department of Health and Mental Hygiene 2004 05638 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 6:05 A M 10, Mease, Jr. **Physician** 2004 Dona_{1d} William /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Lanham 9719 Franklin Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 7 (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 x M 2 □ F June 6, 1959 172-54-3490 44 <u>Pennsylvania</u> Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinar rount by notified at 1 X Yes 2 □ No Maryland Prince Georges Director Lanham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20706 U.S.A. 9719 Franklin Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 198. If Yes, Give Year or Dates: 198. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1983within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify: Baltimore, Maryland 21215-0036 þ 1985 3 ☐ Widowed 4 🖔 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be fited within in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Hotel Manager Marriott 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose K. Donald William Mease, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 289 Joans Quadrangle Road, Front Royal, VA 22630 Pages 1 and 2 Amanda Jo Pataluna/Daughter it of Health other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department of Important: If any injury of once. 2/11/2004 Waldorf, Maryland Huntt Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 alle South 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** (ardie respiratory /Medical Due to (or as a consequence of): **Examiner** Depsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit It a ried Immune - ficient 5- more Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) be detached o 9 Unknown signed by Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? (es 2 4 No 1 ☐ Yes 2 ☐ No 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 1 ☐ Yes 2 📉 No this hours after death. Inere! Director: After this y filled in by the funeral d 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel within 24 hours a
To the Funerel I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2/10/04 MD15084 Washington, DC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1640 Rhode Island Avenue, NW Suite 800 20036 Bruce S. Rashbaum, M.D. 32 egistrar's Signature 31. Date filed (Month, Day, Year) FEB 1 1 2004 State

Registrar

		1 - For State of Maryland / Department of Health and Me Certificate of Death	Reg.		05639
Physic		1. Social in a Marine (1 mar, minorio, East)	2. Date of Death Month	Day Year	3. Time of Death 2315 M
/Medi Examii		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MOWTGON BUY GENERAL HAS PITTE CLOCK TOWN TOWN TOWN TOWN TOWN TOWN TOWN TOWN		4c. County of Death	1614
Funeral Director		129-05-5005 86 Yrs. A	8. Date of Birth (Month, Day, Ye Apr. 28,	9. Birthp Coun 1917 Penns	ace (State or Foreign try) sylvania
Mid I VIGITUAL IN 19-0050 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It is marked other then "naturel", or items 23s or 28s-1 show traumatic event. The Medical Examinar minal be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 3330 N. Leisure World Blvd. #425 20906 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Xives 2 No If Yes, Sive Year or Dates: 1939–46 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Insurance Broker 17. Father's Name (First, Middle, Last) Charles Mignerey 19a. Informant's Name/Relationship (Type, Print) Helen M. Mignerey/ wife 10c. City, Town or Location 10c. City, Town or Location 10f. Zip Code 20906 13. Was Decedent of Hispanic Origin? (Specify Specify Cuban, Mexican, Puerto Rifer Specify Cuban, Mexican, Puerto Rifer Specify Cuban, Mexican, Puerto Rifer Specify only highest grade completed) 15. Decedent's Education (Give kind of work done during most of working life. Do NOT use retired) 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 17b. Mailing Address (Street and Number or Rural of Specify and Number or Rural of Specify Street and Number or Rural of Specify Specify Specify Specify Specify Specify Cuban, Mexican, Puerto Rifer Specify Specify Specify Cuban, Mexican, Puerto Rifer Specify Specify Specify Cuban, Mexican, Puerto Rifer Specify Specify Specify Specify Specify Specify Specify Cuban, Mexican, Puerto Rifer Specify Speci	US ity Yes or No- lican, etc.) g	Citizen of What Coun SA 14. Race - Americ Black, White, Specify: White b. Kind of Business/Inconsurance iden Sumame)	an Indian, etc. Ce lustry
DEMLITIONE, INTERTIFIED PERMIT PAGES 1 and 2 should by Department of Health and Menta Important: If them 27 is marked enry injury or other traumatic enong.		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) W. Arundel Crematory 22, Name and Address of Facility Coing Home Cremation MO1251Beverly I. Heckrotte,	lary 2004 2004 Oc	c. Location - City or To denton, Mar P.O. Box	wn, Stete ry1and 784
cate be executed by projection and cate by sician and cate by sician and cate by the burial-transit	Certification: To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 13 y leading to among a cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	respiratory arrest,		Approximate Interval Between Onset and Death
that the death certificated by the attending produced for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown		cco use contribute to th	Day Year e cause of death?
The The sage		Cowitithtya	24a. Was an autopsy performe	24b. Were autoprior to cord? death?	psy findings available inpletion of cause of
UIVISION OY VICAL Papital or Attending Physician: The outs after death. The Director: After this certificate filled in by the funeral director, pag		27. Manner of Death X Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Accident 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No Yes	ne 5 Residenc 8d. Describe how	et and Number or Rura	
To the Hospital within 24 hours a To the Funerel completely filled	Medical Ce	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number	d at the time, date	and place, and due to Date signed (Month, i	the cause(s) Dey, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		BROWNY 81	LD04
1/12		CHUI. MARGOLLIMO 11125 RECKUME PINE, POCKUME, MO 208	\$52		
St Regis	ate trar	31. Date filed (Month, Day, Year) FEB 1 0 2004 33 Registrar's Signature			

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05641 For State of Maryland Department of Fleath & State of Maryland Department & State of Mary 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:45 P M February 9 2004 Mae Middleton /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Easton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min: (Month, Day, Year)

Capt 10, 19 Talbot Hospice House Talbot Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 2 🛱 F Yrs. Sept 10,1937 Maryland 212-74-7319 66 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director Maryland Talbot Easton 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 12 Park Ln Jensen's Hyde Park 21601 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: white δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) mail processing 11 mail processor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Royer James Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21601 spouse 12 Park Ln Easton, MD Thomas Middleton SR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 02/13/2004 Ridgely, Maryland Ridgely Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home PA 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carc 3 months Due to (or as a consequence of): disease or condition resulting in death) noma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 Tyes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 ☐ Yes 2 No Certification; To 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Division of Vital Records, Physicien: or Attending the Hospital

> State Registrar

DHMH 17 Rev 1/2001

Funeral

Director

item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar most be notified at

Hygiene.

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If Item 27 is marked other the eny injury or other traumatic event, ILA.

Physician

/Medical Examiner

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attending physician

been signed by the atte should be detached for

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Alter this certificate

after death.

within 24 hours a To the Funeral D

funeral director,

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completely

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30. Name and address of

1>R. 31. Date filed (Month, Day, Y

29b. Signature and title of certifier

Deshields

Year)

certificate be executed

Box 68760,

P.0.

death with

filed within 72 hours after

Baltimore, Maryland 21215-0036

dewild

29c. License number

ALK

EXSTON

29d Date signed (Month, Day, Year)

and manner stated.

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

509

State of Maryland / Department of Health and Mental Hygiene 2004 05642 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 9,2004 11:18AM FEB. WILLIAM STACK MORRIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSP. CENTER CLINTON PRINCE GEORGE 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 71 Yrs. | Months Days Hours | Min. | MAY 5, 1932 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 220-28-0097 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Show rotified at 1 ☐ Yes 2 TNo Director MARYLAND FAULKNER CHARLES 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? ms 23a or i 9880 LOMAX ROAD 20632 U.S.A. 14. Race - American Indian, Black, White, etc. 12, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status The Medical Examiner 1 ☐ Yes 27 700 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 ö 1 ☐ Yes 25 No Specify: Completed by WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 6 HEAVY EQUIP. OPERATOR/MECH. GOOSE BAY AGGREG. markad other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental CLARENCE HENRY MORRIS ADDIE M. BIDDLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is DORIS M. MORRIS-SPOUSE 9880 LOMAX ROAD FAULKNER, MD. 20632 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2万℃ remation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) M T 1 = 5 Department of Important: If any injury or once. METROPOLITAN CREMATORY 2-13-04 | ALEXANDRIA, VIRGINIA permit. 21. Signature of Funeral Service Licenses 22, Name and Address of Facility MQ0479 RAYMOND FUNÉRAL SERVICE, P. A. Xs uchae LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CANCER **Physician** UNG resulting in death) /Medical Due to (or as a consequence of): **Examiner** DISEASE AILTELLY OKUNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine death certificate be executed DIABETES resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 JO ENTERITI Physiclan/Medical as the attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 🗌 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed, 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Minpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48128 02-09-2004 and fame 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OXON HILL MD 20745 (LOAD STE 500 6192 OXON HILL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Game & fresh Registrar 2004

State of Maryland / Department of Health and Mental Hygiene 05643 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Veer **Physician** Martz 12 04 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CUMBER LA

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. SACRED HOSPITAL LAND EGAN HEAR 9 Birthplece (Stete or Foreign 5. Social Security Number 8. Dete of Birth May 7, 1925 7. Age (In yrs. last birthday) **Funeral** M 2 ☐ F 215-26-9245 78 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at Allegany LaVale MD Yes 2 No Director 10g. Citizen of What Country? 10e Street and Number 10f Zio Code USA 21502 11110 Arizona Avenue NW 'natural', or iteme 23a permit. Pages 1 and 2 should be filled within 72 hours after death to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22 any injury or other traumatic. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X Yes 2 No If Yes, Give V Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 WWII Specify: white þ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Diesel Master Mechanic Freightliners 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alma (Lothers) Martz William Martz ^{19a.} Informant's Name/Relationship *(Type, Print)* Gail Martz daughter 9b. Mailing Address (Street and Number of Rural Route Number, City or Town, State 7th Code 21502 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Restlawn Memorial Gardens 2/17/2004 MD LaVale * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nan Scarbetti Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 -amus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C use (Final disease or condition resulting in death) **Physician** Respiratory /Medical Due to (or as a consequence of). Examiner Interstitial acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 2 X No 1 🗌 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 2 ER/Outpatient 1 / Inpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred al or Attending P after death. Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Doc 55325 Workockeller Feb 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48 Tarn Frostburg WONSOCK SHIN Terrace MD21532 31. Date filed (Month, Day, Year) FEB 2 0 2004 32 Registrar's Signature State 000 A Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760. has certificate Be Medical Certification: To completely filled in by the funeral within 24 hours after death. To the Funeral Director: After

Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of): d.		
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Part II. Other significant condition	ns contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death	

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 △ Yes 2 □ No 24a. Was an autopsy performed? 1. Yes 2 □ No 25. Was case referred to medical examiner?
1 X Yes 2 □ No 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence & Other (Specify AT SCENE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury accurred Decrased pedestion 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗷 No -26-04 8: ZZ A M 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 403 Prest Covice in 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) 403 Prest Forch Church Ville, Horford Co. MJ 4 - Homicide

		C MOODE C		CHOOL CACO LINE) LELL	0.0 00.1.2
29a. Certifier			ath occurred at the time, date and place,		
(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause one) and manner stated.					and due to the cause(s)
29b Signature an	d time of certifier	$\Omega \Lambda \Lambda$	29c. License number	29d. Date signe	d (Month, Day, Year)

,2004 **OCME JANUARY** 27

of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

05644

3. Time of Death

8:33a

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2X No

FOR

Race - American Indian, Black, White, etc.

Massachu

4c. County of Death

10g. Citizen of What Country?

Specify

16b. Kind of Business/Industry

20c. Location - City or Town, State

Home, IA

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Sign 1

201

State of Maryland / Department of Health and Mental Hygiene 2 05645 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Helen Louise 4:40 P M Noble Jan. 31 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bowie Health Center Bowie Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March 7, 1925 5. Social Security Number 9. Birthplace (State or Foreign Country) New Hampshire 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🂢 F 78 002-18-2076 Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ral", or Items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 No Directo Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 12600 Craft Lane 20715 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ "natural", 3 Widowed 4 Divorced er than "nature". Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry with wontal Hygiene.
T27 is marked other than "v traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Advertising Composition Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental Louis Toole 2 Marion Doherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau once. Robert B. Noble / spouse 12600 Craft Lane Bowie, MD. 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 2-4-Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2004 22. Name and Address of Facility 21. Signature of Funeral Service Licer Beall Funeral Home 6512 NW Crain Highway Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Heart Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No been si should I Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has I rector, page 2 s 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Certification: To 1 Pes 2 No this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending within 24 hours are control to the Funerel Director: Alt 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ause of death (ttem 23a) (Type, Print) Alvander 31. Date filed (Month, Day, Year) 32 bistrar's Signature State 10 FEB Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05646 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February February ^{Day} 2004 **Physician** Matthew Nesmith Sr. 12:07 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Lonaconing egle nursing home If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X**XM 2□ F 87 212-18-1149 Yrs. June 14 1916 Director Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, I'm Medical Exercities must be notified at 1⊠Yes 2 No Director Allegany Westernport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21562 United States 251 Wood st. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 1/20 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 ☑ XIO Specify: þ 3€Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Deportment of Health and Mental Hygiene. Important: If Item 27 is marked other than any njury or other traumatic event, Ital Mentagone. Elementary/Secondary (0-12) College (1-4or 5+) Paper Manufacturer Skid Finisher unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Luther Nesmith Sara Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerry Mayles/ daughter 312 Hammond St., Westernport, Maryland 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 02/04/ 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Keyser, West Virginia ¥ 4 □ Donation 5 □ Other (Specify) Potomac Mem. Gardens 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home +- W as 111 Church St., Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gente Cerebroros cular Accident **Physician** 48hours /Medical Due to (or as a consequence of): Examiner Generaliz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Physician/Medical ası the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ট Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Seknown icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 1 Yes 2 🗆 No 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

within 72 hours after

Maryland 21215-0036

Baltimore,

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

or Attending

Hospital

the

State Registrar 31. Date filed (Month, Day, Year) - 2 2004 FEB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D21244

			For State Registrar	State of Maryland	/ Depa	artment of F	leaith and Death	F	leg. No.	
	Physicia /Medic Examin	al .	1. Decedent's Name (First, Middle, Last) Marvell Aletha 4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, o		2. Date of Dea Month Februa	Day CY 3, 20 4c. County o	f Deeth
	Funeral Director		Crofton Convales 5. Social Security Number 6. Sex 224-28-1844 Usuel Residence of Decedent		birthday) Yrs.	Croft If Under 1 Year Months Days	O D If Under 24 Hr Hours Min		Anne (,1921	Arundel 9. Birthplece (State or Foreign Country), Virginia
	the Maryland or 28e-f ehow	Director	10a. State 10b. County Maryland Anne Ai 10e. Street and Number	cundel Edg	own or Lo gewa				10g. Citizen of Wi	10d. Inside City Limits 1 ☐ Yes 2 ☐ No nat Country?
036	within 72 hours after death with the Maryland ene. 196. 197. 198. 19	by Funeral	320A Fairmount 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Drive 2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			037 lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- no Rican, etc.)	Black	- American Indian, , White, etc. White
Maryland 21215-0036	be filed within 72 hor tal Hygiene. d other than "natura avent, the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 9 t h		(Give	dent's Usual Occup kind of work done DO NOT use retired hnician	during most of wo			1 Government
/aryiana	2 should and Men is marke raumatic	To Be	17. Father's Name (First, Middle, Last) Walter Wal 19a. Informant's Name/Relationship (Type Gary J. Poore/S	oe, Print)			Bertha and Number or F	a Mae (U Bural Route Numbe	nknown r, City or Town, S) Itate, Zip Code)
a,	90 = 5		20a. Method of Disposition 1	emoval from State 20b. Place certification Lake	e of Dispo etery, crei ⊇mon	esition (Name of matory or other place t Mem. Ga	ardens 2	Date -12-04 I	20c. Location - 0	, Mr. 21037 City or Town, State
Bail	permit. Pac Department Important: eny injury once.		21. Signat of Funeral Service License 23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death. I	Do not ent	973 Solor er the mode of dyir	nons Isl	and Rd.,E	Edgewater	neral Home c, Md.21037 Approximate Interval Between Onset and Death
760,	Physician /Medical /Reginal and per partial francis // Action of the performance of the p	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initieled events resulting in death) Last	Due to (or as a consequent Due to (or a)	nce of):	3 Mucheus	2 Jul	marceey		e e e e e e e e e e e e e e e e e e e
O. Box 68	The law requires that the death certificate tate has been signed by the attending physic page 2 should be detached for use as the tate.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	eath 3	Ectopic pregnancy	1		23d. Date Mont	of delivery h Day Year
2	w requires that been signed b should be deta		Part II, Other significant conditions con	tributing to death but not resulting	ng in the u	nderlying cause giv	en in Part I.			bute to the cause of death?
tal Records,	sicien: The law r certificate has be lirector, page 2 sh	e Completed by	Procumonia 25. Was case referred to medical				26 Place of De	24a. Was a autop perfor 1 Yes	sy pr med? de 22 No 1 [ere autopsy findings available for to completion of cause of aath? Yes 2 No
ion of Vital	Phy raid	To B	examiner?		VOutpatier Bb. Time o Injury	f 28c. Injur Wor	er: Nursing	Home 5 Resid		
Division	Hospital or Attending 24 hours after death. Funeral Director: Afte itely filled in by the fune	Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)				City or Tow	n, State)	r or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Physical Examination (Check only one) Medical Examination (Check only one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	n and/or in	vestigation, in my c	opinion, death occ	curred at the time, o	date and place, ar	ner as stated. Ind due to the cause(s) (Month, Day, Year)
	T COO			mpleted cause of death (Item 23	3a) (Type.	DS	57028	3	02-04	9-04
	Sta Registi		30. Name a addr of coson who co	M.D. GOO RIP		1 AVEST	E231;	ANNAPI	ULIS, Fr	W. 21401

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 05648 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Helen Lucille Phipps 3:10 P /Medical February 1 2004 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Arundel Medical Center Serundo Number 6. Sex 7. Age (In yrs. last birthday) Anne Arundel Annapolis
Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year March 21, Birthplece (State or Foreign Country) **Funeral** Year) 1 ☐ M 2 😭 F Months Days Hours Min 1909 Maryland 94 Director 212-05-0348
Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or Items 23s or 28s-f show the Medical Exercitor must be notified at 1 Yes 2 No Director Maryland Anne Arundel
10e. Street and Number Annapolis 10g. Citizen of What Country? 10f. Zip Code United States 21403 death Funeral 1002 Boucher Avenue Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status itied within 72 hours after I Hygiene.

other than "natural, or Ite 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: δ white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed v f Health and Mental Hygie item 27 is marked other t other traumatic event, Ill phone company
18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) operator Be Ida King Thomas Monday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Heatth a ant: If item 27 is jury or other tra 1002 Boucher Avenue Annapolis, MD 21403
Disposition (Name of Date 20c Location - City or Town, State Schultz/ nephew Larry SCNULI
20a. Method of Disposition Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Cedar Bluff Cemetery 2-9-04 Annapolis, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc Romandu 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Nalale disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Reveltio dequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed 100 burial-tran and resulting in death) Last Due to (or as a consequence of): the attending physician ned for use as the burial P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown 9 🗌 Unknown s been signed by the 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ torille 3 ☐ Probably → Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? certificate 1 Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 2 Accident 5 Pending ours after death. saral Director; Af filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funaral Dire To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State FEB 0 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05649 For Stete Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** James A. Plitt, Sr. Feb. 4, 2004 6:15 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Corsica Hills Nursing Center Centreville Oueen Anne's 8. Date of Birth (Month, Day, Year) Apr. 18,1912 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 15 M 2 ☐ F 91 Director 212-05-2360 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Show Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at MD Queen Anne's Centreville 1 ☐ Yes 2 X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 Armstrong Avenue 21617 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify. 3 XWidowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President/Treasurer Trucking Company 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Item 27 is marked oth any july or other traumatic event ang. 18. Mother's Name (First, Middle, Maiden Sumame) Be Emil Plitt Katherine Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine P. Mylander/Daughter P.O. Box 103, Oxford, MD 21654 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Feb. 6, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Parranco & Sons, P.A. Severna Park Funeral Home 495 Gov. ritchie Hwy, Severna Park, MD 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finat disease or condition **Physician** neumonin resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any last in 1. Immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consa uence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physiclan/Medical tF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐ Yes 2 ☐ No 9□ Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 of Vital Records, should be Q'a beter 3 ☐ Probably 4 ☐ Unknown Completed 1 ☐ Yes 2 ☐No peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After **Division** 1. Natural 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No the 2 Accident 6 Could not be determined 3 Suicide 4 Homicide in by t Pface of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ō To the Hospitel completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 132036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mine Cherter, MD 2/6/9 2108 didary ase 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature State FEB 0 9 2004 Registrar

_		Ľ	For State Registrar	te of Maryland	/ Depa	artment of H tificate of L	lealth and Death	Mental Hy	/giene2 0	04 0	5650
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of D Month	eath Day	Year 3.	Time of Death
	/Medic		Rosella Sadie P					Feb			:20 PM
	Examin	er	4a. Facility Name (If not institution, give street a			4b. City, Town, or		th	4c. County		
			Genesis ElderCare 5. Social Security Number 6. Sex	- The P1		If Under 1 Year	aston If Under 24 Hrs	8. Date of B	irth	albot	/State or Foreign
	Funeral Director		217-12-4735		Yrs.	Months Days	Hours Min		ay, Year)	Maryl	(State or Foreign
	ס		Usual Residence of Decedent					Textile	1 0, 1020	rar yı	and
	how		10a. State 10b. County	10c. City,	Town or Lo	cation					nside City Limits
	e Ma Sa-f s	cto	Maryland Caroline	De	nton						☐Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
	s 23s	Funeral Director	7849 Harmony Road	0	140	21629	01101		United S	tates	dian
	itam Itam	n.	Am	s Decedent Ever in U.S. led Forces? Ves 2 □ No	. 13.	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Pue	rto Rican, etc.)		k, White, etc.	idian,
36	irs af	Ą	3 Widowed 4 Divorced	Yes 2 □ No es, Give X ir or Dates:		1 ☐ Yes 2X No	Specify:		Specify	aucasia	an
nger 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If flem 27 is marked other than "natural", or Itams 23a or 28a-f show or other treumatic event, the Mudical Examilitational by redifficial at	Be Completed by	15. Decedent's Education		16a. Dece	tent's Usual Occupa	ation		16b. Kind of Bu		
er 215	hin 7 9.	pie	(Specify only highest grade comp Elementary/Secondary (0-12) Coll	erea) ege (1-4or 5+)	life.	kind of work done of OO NOT use retired	ouring most or wo	orking			
	filed wit Hygiene ether the	9	9		Cafe	teria Mar			Element		nool
Pittinger Maryland 2121	be file	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	e, Maiden Surnam	e)	
X ta	should Ind Ment	ဥ	Jesse Lee Reed					h Griffi			
Pi Many	2 sh and lem reum		19a. Informant's Name/Relationship (Type, Prin	1.5		g Address (Street a					e)
	t and tealth sm 27 ther tr		Francis L. Pittinger 20a. Method of Disposition	Husband 20h Plac		Harmony		enton, M	laryLand 20c. Location -		State
Rosella Baltimore ,	Pages nent of Hint: If Ite		1 ☑Burial 2 ☐ Cremation 3 ☐ Remova	from State	netery, crer	sition (Name of natory or other place	!			035.00.0000000	
Se			* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Den		emetery . Name and Addres		4/2004	Denton,	Maryla	and
Ro Bal	Departi Departi Importi any inj		The such that	lare	М	core Fune	ral Hom	e, P.A		-	
		-	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death.	Do not ent	2 South S	econd S	treet, L	enton, M arrest.	App	roximate
			shock, or heart failure. List only one caus Immediate Cause (Final	e on each line.	^			1.7		Inter Ons	rval Between et and Death
	Physician / /Medical		disease or condition resulting in death)	ue to (or as a conseque		ncer-	Meh	ASTATIC		_	
2000	Examiner			ue to (or as a conseque	inoa orj.						
		ē	Sequentially list conditions, if any leading to knn edite cause. Enter Underlying Cause (Disease or injury	ue to (or as a consecue	nce of						
	cuted	Examiner	that initiated events								
0	e exectan ar			ue to (or as a conseque	nce of):						
8760,	cate be executed physician and the burial-transit	Physician/Medical	d							27.23	
39	The law requires that the death certificate has been signed by the attending places 2 should be detached for use as it	Med	IF FEMALE:								
80)	ath co	lan/	230. Was decedent pregnant	es, outcome of pregnand Live birth 2 Petal d	eath 3□	Ectopic pregnancy			23d. Date Mon	of delivery th Day	Year
o.	he de the a	ysic	1 TV00 2 MN0 4	Pregnant at time of dea Unknown	ıtn 5∟	Other (specify)					
Division of Vital Records, P.O. Box 6	w requires that the death certific been signed by the attending p should be detached for use as		Part II. Other significent conditions contributing	g to death but not resulti	ing in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use contri	bute to the cau	use of death?
ds,	uires sign Id be	Completed by	multiple My-	elem A				10	Yes 2 ∑No	3 Probably	4 DUnknown
õ	w required been shou	ete	11 005 1005					24a. Was	s an 24b. W	/ere autoosy fi	ndings available
Re	helav ehas ge 2	g E	14 yes tension	`				auto	ormed/ d	eath?	ndings available ion of cause of
<u>re</u>	rsician: The law s certificate has to lirector, page 2 s		25. Was case re-irred to medical	110)			28 Place of De	1 ☐ Yes ath (Check only		Yes 2	No
Ş	Physician: r this certifica ral director, p	To Be	examiner? 1 Yes 2 No Hospital	1 ☐ Inpatient 2 ☐ EF	R/Outpatien	t 3 DOA Othe			idence 6 □Othe	r (Specify)	
2	g Phy erthi		27. Manner of Death 28a.		8b. Time of		the second secon		how injury occurre		
<u>.</u>	Attending or death. ector: After by the fune	atio	1 Vatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 16al)	Injury		res 2 □No				
<u>vis</u>	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e.	Place of Injury - At hom building, etc. (Specify)	ie, farm, str	eet, factory, offica		28f. Location ((Street and Numbe	r or Rural Rou	te Number,
ā	itel or A rs after el Direc led in by	Cer							_	~	
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: 2 ☐ Medical Exeminer: On and	To the best of my knowle the basis of examination I manner stated.	edge, death n and/or inv	occurred at the time restigation, in my op	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and mar , date and place, a	nner as stated. nd due to the o	cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License			29d. Date signed		
			1/2	To		441	818		2-10-	2004	
			30. Name and address of person who complete	leause of death (Item 2	23а) (Туре,	Print)	4.	1 0	7-	i .	21601
_			PATVICX S	terling		508 I	dowl	d Hre	2-10- Ens-	ten M!	7
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 1 2004	32. Registrar's Signatur	De Mark						

04-1156 B.

• K	.S.		Please	ype or Print in Black				
eg	gy Lee	Pay	V ¹ Offor 1 - State Registrar Unpend Item#	State of Maryland / Di 3a,27,Per ME,G828,3/4	epartment of Health and Wrei ficate of Death		iene2004 0565	I
			Decedent's Name (First, Middle, Las	1)		2. Date of Deat Month		
	Physici /Medi		Peggy Lee Paylor			Febuary	11 2004 1550 P	И
	Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea		4c. County of Death	
			1740 Edgewood Hil		Hagerstown		Washington Count	
	Funeral Director		219-52-0872	7. Age (In yrs. last birth	Months Davs Hours Mil		9. Birthplace (State or Foreign Country) 17, 1949 Maryland	חן
	and *		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town	or Location		10d. Inside City Limit	S
	Maryll	jo	Maryland Washingt	on Hanco	ck		1 Yes 2 N	0
	28a	rec	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Country?	_
	h with	Funeral Director	13834 Hollow Road		21750	,	U.S.A.	
	deat	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian, Black, White, etc.	
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or fleme 23a or 28a-f show event, if a Medical Examinat he notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	,	Specify: White	
9	72 ho	Completed by	15. Decedent's Ed (Specify only highest gra-	ucation 16a. [Decedent's Usual Occupation Give kind of work done during most of w	ndkina	16b. Kind of Business/Industry	
2	within 7 ene. than "r	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done during most of w life. DO NOT use retired)			
21	filled wi Hygien ther th	ပ်		2	Constable		District Court of MD	
pu	be fill H d oth	Be	17. Father's Name (First, Middle, Last)			ame (First, Middle, I	Maiden Sumame)	
3	should by nd Menta marked umatic ev	2	Tee H. Wolf	ima Brinth 10h	VIIGIII Mailing Address (Street and Number or F	ia Weaver	City or Tourn State Tip Code)	_
Maryland	ith ar 27 is r trau		19a. Informant's Name/Relationship (1 Richard Blair Pay		3834 Hollow Road,			
ē,	s 1 and of Health Item 27 other tr	- 5	20a. Method of Disposition	cemetery	Disposition (Name of crematory or other place)	•	20c. Location - City or Town, State	
Ë	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Hemoval from State Smiths	burg Crematory Feb	. 17, 200	4 Smithsburg, Maryla	nc
Baltimore,	permil. Pages Department of Importent: If I any injury or I		21 Signatur Funeral Service Licen	500	22. Name and Address of Facility D	ouglas A.	Fiery Funeral Home	
<u> </u>	89 = 2	10 11	1 august	1. Finy	1331 Eastern Blvd		rstown, Maryland 217	42
	Physician /Medical Examiner	er	shock, or heart fure. List only in mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	a. Due to (or as a consequence of Due to (or as a consequence		ovascular D	Interval Between Onset and Death	
3760,	ate be executed hysician and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of				
P.O. Box 68	that the death certificate I ed by the attending physi detached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year	
	96 96	by	Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause given in Part I.		pacco use contribute to the cause of death? as 2 □ No 3 □ Probably 4\2\1000Unknow	'n
of Vital Records,	0 - 0	Completed				24a. Was a autops perform	y prior to completion of cause of death?	le
tal	ician: Th certificate rector, pag	0	25. Was case referred to medical	V-22-7	26. Place of D	eath (Check only on		_
>	Q 12	To B	examiner? 1XXYes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Other: 4 Nursing	Home 5 Reside	ence 6 DOther (Specify)At Scene	
o uo	ding Ph h. After th funeral		27. Manner of Death 1 ■ Natural 5 ■ Pending 2 □ Accident		me of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe ho	w injury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined		m, street, factory, office	28f. Location (St City or Town	reet and Number or Rural Route Number, , State)	
	e Hospital 24 hours a e Funeral D etely filled i	ledical (29a. Certifier 1 Certifying Ph (Check only one) 1 Certifying Ph	ysician: To the best of my knowledge, niner: On the basis of examination and and manner stated.	death occurred at the time, date and pla /or investigation, in my opinion, death oc	ce, and due to the courred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)	
	To the within 2 To the complet	₹ E	29b. Signature and title of certifier		29c. License number	2	9d. Date signed (Month, Day, Year)	-
	- > - 0		The M	Vin.	O.C.M.E.		Feb. 12, 2004	
			30. Name and address of person who	completed cause of death (Item 23a) (1	Type, Print)			
			Theodore M. Kir		et, Baltimore, Mary	land 212	01	
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1. A	,		
	Regist	rar	FEB	2 3 200	15 Love les			

State of Maryland / Department of Health and Mental Hygiene 004 05652 State
Registrar Amend Item#21perDVRG8282/21/04 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2127 Kicharc Alebruary 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Washington County Hospital Hagerstown
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1₫M 2□F 187-16-6881 84 Yrs. Director Jan. 16, 1920 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exeminer mout be notified at 14 Yes 2 □ No Maryland Washington County Funkstown Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code , or items 23a or 110 Stouffer Ave. 21734 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cupan, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify ģ 3 XWidowed 4 □ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Gas Station 12 other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event ans. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Raymond C. Paylor Maude Rinedollar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Paylor/Son 5555 Royer Road Greencastle, Pennsylvania 17225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Feb. 3, 2004 Smithsburg, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Douglas A. Fiery Funeral Home 1331 Eastern Blvd.N. Hagerstown, Maryland 21742 21. Signature of Funeral Service Licensee Douglas A fiery per DVR Moo663 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. oproximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Antylingdi-c to m /Medical Due to (or as a consequence of): **Examiner** Condicumular 3~ Luc ntens siles Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed use as the burial-transit Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Caratana ciden Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 No 1 Tes 1 Yes 2 1√10 of Vital Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EFFOutpatient 3 ☐ DOA 1 Yes 2€No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Attending Injury Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funaral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 6 Pelli Medical 🖯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D18219 FES 2, 2004 -CENTERUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m O VASANT DATTA 21740 MAKERITOWN no 340 MILLIT 31. Date filed (Month Pax Year) 5 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05653 1 - State Certificate of Death

			- Hegistrar				Tillicate	OIL	Jeani			Reg. No		
	Physic /Medi		1. Decedent's Name (First, Middle, Las Webster Francis	,							2. Date of D Month Februa	eath Dary 6	, 2004	3. Time of Death 1:10 AM
	Examir		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location	of Death			County of Dea	th
			Anne Arundel Med	ical Ce	nter		An	napo	lis				Anne Ar	undel
	Funeral Director		070-14-4172	ex Mg M 2□F	7. Age (In yi	s. last birthday, Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D August	rth ay, Year) 23,	9. Bin 1920	thplace (State or Foreign buntry) New York
	p ,		Usual Residence of Decedent 10a. State 10b. County		1.0									
	death with the Maryland ms 23a or 28a-f show (must be rotified at	Director	Maryland Anne A	rundel	100.	City, Town or L		Crow	nsvi.	lle				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28)Ire	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What Co	ountry?
	23a		1143 Claire Road					2	1032				U.S.A.	
	ter dea Items	Funeral	11. Marital Status	12. Was Dece Armed Fo	dent Ever in	U.S. 13.	Was Deced	ent of His	spanic Ori	igin? (Spe	cify Yes or N	0-	14. Race - Ame Black, Whit	
980	g 9 E	by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 X Yes			1 ☐ Yes 2		Specify:		noun, oto.,			White
5-0	72 hours "natural",	ted	15. Decedent's Ec (Specify only highest gra	lucation		16a, Dece	dent's Usua	Occupa	tion			16b. Ki	ind of Business/	Industry
Maryland 21215-0036	12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "r traumatic event, tra Med	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		kind of work DO NOT usi					IJ	S. Gove	rnment
b	i Hyg othe	Be C	17. Father's Name (First, Middle, Last)								(First, Middle			LIMICITE
/lan	uld be Venta Irked Itic ev	To B	George Russell						Oı	rel M	ulanif	f		
an	2 sho and 1 is ma		19a. Informant's Name/Relationship (7	., . ,		19b. Maili	ng Address	(Street ar	nd Numbe	er or Rural	Route Numb	er, City o	r Town, State, Z	Tip Code)
	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai		Lisa Roney/daugh	ter				-	oad	Crow	nsvill	e, M	2103	2
ore	of H of H if iter		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from 9	State	Place of Dispo cemetery, crea	matory or oti	her place			ate	20c. Lo	cation - City or	Town, State
Ē	Pag ment ant: ury c		`4 □Donation 5 □ Other (Specify	")	Ba	ltimore		-		2/11/		Balt	timore,	MD
Baltimore,	Depart Import any inj		21. Signatu - Funera Service Licen	See /	111	2:	2. Name and	Address	of Facilit	y Joh	n M. T	ayloı	r Funera	al Home
_	70 E # 9		Todd E	1 Xu	Kle.								apolis,	MD 21401
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	icii iine.		ter the mode					rrest,		Approximate Interval Between Onset and Death
	Examiner				or as a conse	equence on):	((1)	-hys	· · · · · ·	1100		6	600
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (d	or as a conse					- 01				
,00	th certificate be executed lending physician and r use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (d	or as a conse	equence of):		-						
876	ate b	llca		d										A27-500
.O. Box 68760,	res that the death certific igned by the attending p be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outc 1⊟Live bii 4⊟Pregna 9⊟ Unkno	nth 2 ☐ Fe untat time of	tal death 3□	Ectopic pre	gnancy cify)				2	3d. Date of deli-	very Day Year
a	that the	P	Part II. Other significant conditions co	ntributing to de	ath but not re	eulting in the u	ndashina aa	una anvar	in Dard I		120 Dids			the cause of death?
rds,	w requires been signe should be	Δ.						usa givan				obacco di Yes 2\⊊	_	bably 4 Dunknown
Records,	e la has	Completed									24a. Was autop	osy	prior to co	opsy findings available ompletion of cause of
_	ician: The certificate harector, page		OF Man ages where the								1 Yes		death?	2 🗆 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital				Other			Check only o			
of	Phy r this sral d	-	1 Yes 2 700			ER/Outpatien 28b. Time of		1	4 1401		e 5 ☐ Resid ld. Describe h		Other (Speci	fy)
Division	Attending Physician: r death. ector: After this certifics by the funeral director.	catlon	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month	, Day Year)	Injury	M	c. injury a Work? 1 🔲 Ye	n os 2 □ N		d. Describe i	iow injury	occurred	
Divis	ial or Attensis after deat	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of building	of Injury - At I g, etc. (Spec	home, farm, stre ify)	eet, factory,	office		28	f. Location (5 City or Tox	Street and vn, State)	Number or Rur	al Route Number,
	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medicel Exem	sician: To the basiner: On the basiner	sis of examin	nowledge, death ation and/or inv	occurred at restigation, in	the time,	, date and nion, death	place, an	d due to the	cause(s) a date and	and manner as s place, and due t	stated. to the cause(s)
	To the Comp		29b. Signature and title of certifier				29c.	License r	number			29d. Date	signed (Month,	Day, Year)
•			An I Sow	ne N	0			D	324	36		2/	6/2000	1
			30. Name and address et person who co	ompleted cause	of death (Ite	m 23a) (Type, 1	Print)							

State

Registrar

Gan 31. Date filed (Month, Day, Year)

FEB 0 9 2004

Sprose 2108 Di Danto Drive Cherkino 21619

			1 - For State Registrar	State of M	Marylar	nd / Depa <i>Cei</i>	artmen rtificat	t of H	lealth a Death	and Mo		giene (2004	056	554
			1. Decedent's Name (First, Middle, Last,)							2. Date of Dea			3. Time of 0	Death
	Physici /Medi		Helen ElizabetI	n Reese							Januar	y 30	2004	7:00P	М
	Examir		4a. Facility Name (If not institution, give Northampton Mano:	street and number Health	Care			Town, or rede	Location o	of Death		4c. C	ounty of Death rederic	ck	
	Funeral Director		5. Social Security Number 220-26-5469 6. Sec	х]м 2 1 г	Age (In yrs.	last birthday) 6 Yrs.	If Under Months	1 Year Days	If Under Hours	Min. S	8. Date of Birth Month, Day ept. 23	, Year) 191	7 Mar	place (State or ntry) y land	Foreign
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	onting								
	danyla aho	ō	Maryland Frederi	ck	100.01			• •	1 1					10d. Inside City 1 ☐ Yes	
	the A	Director	10e. Street and Number	CK		w	Valke:		i i e			On Citizo	n of What Cou		
	3a or		10303 01d Annap	oolis Rd			101. 2.10		1793			-	.S.A.	nuy:	
	death	Funerai		12. Was Deceder	nt Ever in U	l.S. 13. \	Was Deced			gin? (Spec	ify Yes or No- ican, etc.)		Race - Amen	can Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumatic event. The Medical Examiner must be multilied at once.	by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Dates	No		fYes, spec 1 ☐ Yes		n, Mexican Specify:	i, Puérto R	ican, etc.)		Black, White, Decify: Whi		
Ö	72 ho	Completed	15. Decedent's Edu	cation		16a. Deced						16b. Kind	of Business/In	dustry	
2	thin 7	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4a	r 5+)	life. L	kind of wor DO NOT us	rk done d se retired,	uring most)	of working	9				
7	ed wi	Con	11			S	eamst	ress	5			cl	othing	factory	У
ğ	be fil stal H od oth	Be	17. Father's Name (First, Middle, Last) Walter R. Strine								First, Middle, I		ımame)		
2	d Mer narke	T ₀				1 40 44 11					Haines				
Maryland	d 2 sl th and 7 is r traur		19a. Informant's Name/Relationship (Ty Shirley Fogle/ dau				3 Ke1				Route Number				
ē,	Heal Heal tem 2		20a. Method of Disposition		20b. F	Place of Dispos	sition (Nam	ne of	1	Wall	kersvil		MD 21/5		
ē	ages ant of nt: If if		P☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stat	e	emetery, cren nganor	natory or of	ther place		73/2			nville,		
Baltimore,	permit. F Departmi Importar any injur		21. Signature of Funeral Service Liceose	x/ h	0.	/ 22	. Name and	d Addres	s of Facility	Har	tzler F	unera	al Home		
	40240	-	23a. Part1. Enter the disease, or compli	Mary		.	11802	Lib	erty	Rd.	Libert	ytowr	n, MD 2		
):	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or a	こことの こことの こことの こことの こことの こことの こことの こことの	STIVE 1								Approximate Interval Betwee Onset and De	
8760,	icate be executed physician and sthe burial-transit	dicai Examiner	dany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a											
O. Box 6	The law requires that the death certificate be executed as the best signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Ideath 3 🗌	Ectopic pre					23d	. Date of delive Month	ry Day Yea	ar
Records, P.	uires tha signed la d be det	þ	Part II. Other significant conditions con			ulting in the un	iderlying ca	iuse givei	n in Part I.		23e. Did tob			e cause of dea	
Ö	w require s been si should b	lete									24a. Was ar			osy findings av	allable
		Completed									autopsy	/	prior to con death?	npletion of cause	se of
Vital	ysician: Is certific director,	o Be	25. Was case referred to medical examiner?	ospital:				Other			Chack only one	-			
o	Phys	Hill	1 Yes 2 No	28a. Date of Ing (Month, D		ER/Outpatient 28b. Time of		^	ANUT NUT		5 Reside)	
0	oding F ith. : After s funera	tior	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year)	Injury	М	Bc. Injury Work?	?" es 2 □ N		0000.100 110	w injury oc	A COLLEGE		
Division of	I or Attendia after death. Director: A I in by the fu	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	njury - At ho etc. <i>(Specif</i> y	ome, farm, stre	et, factory,	office		28	Location (Str City or Town,	eet and Ni State)	umber or Rural	Route Number	r.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the bes er: On the basis and manners	or examina	wiedge, death tion and/or inve	occurred a estigation.	it the time	e, date and nion, death	place, and occurred	d due to the ca at the time, da	use(s) and te and pla	f manner as sta ce, and due to	ated. the cause(s)	
	To th within To the compl	Me	29b. Signature and title of courter	1			29c.	License	number		29	d. Date si	gned (Month, L	Day, Year)	
1	10-			V				D3	2171	l		2	12/04		
	My	1	30. Name and address of person who cor	npleted cause of	death (Item	23a) (Type, F	Print)				1	100			
	•		RICHARD L. GO		0 1300		WALL	Lorsu	الدف	MD	21793				
	Sta	-	31. Date filed (Month, Day, Year)		rar's Signa										
16.	Registra	Ir I	EER 0.5.2	ונחחי	0 . 0	1	1 1								

	in the Marylan or 28a-f ehow e neillige et	Funeral Director	MD Howard		Ellico	tt City 10f. Zip Code		10	g. Citizen of What C	1 ☐ Yes 21€ No
	23a c	aiD	3000 N. Ridge R	oad		21043	3		United St	ates
36	rs atter deal	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 Yes, Give Year or Dates:	ło	Was Decedent of H ff Yes, specify Cub. 1 ☐ Yes 2 🗓 No	dispanic Origin? (S) an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify:	erican Indian, ite, etc. hite
215-0036	init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland criment of Health and Mental Hygiene. ordant: If item 27 is marked other than "natural", or items 23a or 28a-f show ordant: my or other traumatic event, the Mayleal Exaciding Land be inclined at injury or other traumatic event, the Mayleal Exaciding Land be inclined at the control of the property of the proper	Completed I	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education	+) (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of world)	king	16b. Kind of Business	s/Industry
2	ygier ygier It,		8	-41	HO	memaker	19 Mothode Nag	ne (First, Middle, M	Own Hom	<u>e</u>
and and	be fi	Be	17. Father's Name (First, Middle, La Michael Mullen	Si)			Rosina		alder Sumarrey	
<u> </u>	hould d Mer mark matic	2	19a. Informant's Name/Relationship	(Type Print)	19b. Maifi	ing Address (Street			City or Town, State,	Zip Code)
Maryland	id 2 s ith an 27 is r traur		Dennis L. Roach			Hernwood				,
ore,	iges 1 ar of Hea H item or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Ž Removal from State	20b. Place of Disponentery, cre	osition (Name of matory or other pla	ce)	Date 2	Oc. Location - City or	
Baltimore,	permit. Pages 1 and 2 Deportment of Health a Important: If item 27 is any injury or other tra once.	1	*4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Li		1044 2		ss of Facility Ha	rry H. Wi		mily FH Inc , MD 21043
	hysician		23a. Part1. Enter the disease, or constant shock, or heart failure. List or firmediate Cause (Final disease or condition	ly one cause on each fir	the death. Do not en	ter the mode of dyir	ng, such as cardiac			Approximate Interval Between Onset and Death
	Examiner	ъ	Exquentially list conditions, if any leading to immediate	8	Advanced a consequence of):	Dementica	-			10 ar
	ate be executed tysician and he burial-transit	Ical Examin	Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last	с.	a consequence of):					ngars
. Box 68760,	the death certificate be executed y the attending physician and ched for use as the burial-transit	ıysician/Medical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 5 No 9 Unknown	c. Due to (or as	a consequence of): of pregnancy 2 Fetal death 3[□Ectopic pregnanc: □ Other (specify)	9		23d. Date of de Month	
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l Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certifuer death. Director: After this certificate has been signed by the attending in by the tuneral director, page 2 should be detached for use as	To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition Hypertens 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga investiga 3 Suicide 6 Could no determin 29a. Certifier	Due to (or as d. 23c. if yes, outcome 1	a consequence of): of pregnancy 2	other (specify) underlying cause given to 3 DOA out to 28c. Injury Wor M 1 reet, factory, office th occurred at the tit	26. Place of Dea 26. Place of Dea er: ★ Nursing H y at k? Yes 2 □ No me, date and place pinion, death occu	24a. Was ar autops) perform 1 Yes 2 th (Check only one ome 5 Resider 28d. Describe hor 28f. Location (Str. City or Town, and due to the carred at the time, da	Month acco use contribute to seed and Number or Residue.	othe cause of death? or the cause of death? or bably 4 Unknown utopsy findings available completion of cause of s 2 No ecify) oural Route Number, s stated. e to the cause(s) th, Day, Year)

		1 - For State Registrar	State of Maryland		artment of Hetificate of L		and Mental	Hygier Reg. 1	_ Z = 111	05656
Physicia	an	Decedent's Name (First, Middle, Last					2. Date of Month		Day Yeer	3. Time of Death 10:10am
/Medic	al	Willis H. Ricke: 4a. Facility Name (If not institution, give			4b. City, Town, or	Location of	Febru	-	10, 2004 4c. County of Dee	4
Examin	er	6705 Carlinda Ave			Columb				Howard	
Funeral	W1	5. Social Security Number 6. Se	x 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Date of Month	f Birth , Day, Yea		thplace (State or Foreign ountry)
Director		218-18-6132	^{XM 2□ F} 79	Yrs.			12/24	/1924		ryland
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
Many a-fsh	tor	Md. Howard	Col	Lumbia						1 ☐ Yes 💃 ☐ No
death with the Maryland rms 23e or 28e-1 show create be notified at	Oire	10e. Street and Number			10f. Zip Code			10g. (Citizen of What C	ountry?
s 23a	rall		Ave. 12. Was Decedent Ever in U.S	12.1	2104		nin? /Specify Ves	r No-	USA 14. Race - Am	erican Indian
s 1 and 2 should be tied within 72 hours after death with the Marylan the match and Marylan Hygiene at the state at 18 and 18 or 28e-1 show them 21s marked other than "natural", or itsems 23e or 28e-1 show other traumatic event, the Medical Evanthas mant to notified at	by Funeral Director	11. Marital Status 1 Never Married 2X Marned 3 Widowed 4 Divorced	Amed Forces? 1X Yes 2 No 1945- If Yes, Give Year or Dates: 1947	- 1	Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 ☑ No	Specify:	Puerto Rican, etc	.)	Black, Whi	te, etc.
2 hou		15. Decedent's Edi (Specify only highest grad	ucation	16a. Deced	dent's Usual Occupa kind of work done d	ition	of working	16b.	. Kind of Business	/Industry
vithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired))	or working		Print	ing
filed v Hygie ther t		12 17. Father's Name (First, Middle, Last)		PI	inter	18. Mother	r's Name (First, Mi	ddle, Maid	len Surname)	
ould be fill Mental Hy arked oth	To Be	Willis H. R	ickert Sr.			Anr	nabelle	Hasse	el	
d 2 should In and Meni	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailin	g Address (Street a	nd Numbe	r or Rural Route N	umber, Cit	y or Town, State,	Zip Code)
1 and 1 Health 10m 27 other tr		Craig Richert/son			Brighton	.Dam	Rd. Clar		Le Vid. 2	
Peges 1 nent of H ont: If Ite		20a. Method of Disposition © Burial 2 □ Cremation 3 □	Removal from State	metery, cren	natory or other place Memorial		2/14/2004		•	
그 문문을 .		* 4 □Donation 5 □ Other (Specify, 21. Signature of Funeral Senfine Libers								lly F.H.Inc.
Depa Impo Impo any ii		Amout Ch	MO0845		12 01d Co					
Physician /Medical Examiner physicien and physicien and the prijal-transit	Ical Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a conseque	ence of): UST (Connection of):	CELL ROM'S M					Interval Between Onset and Death S. Months 4 Years
death certific	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetel 4 Pregnant at time of dea	death 3□	Ectopic pregnancy Other (specify)				23d. Date of de Month	livery Day Year
law requires that the dias been signed by the 2 should be detached	by	Part II. Other significant conditions or	entributing to death but not resul	ting in the u	nderlying cause give	in in Part I.	111	_		o the cause of death?
0 2 9	Completed							Was an autopsy performed les 2 2	? prior to death?	utopsy findings available completion of cause of
Physician: The this certificate rat director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0.4		of Death (Check of	101		
at di	. To	1 Yes 2 No 27. Manner of Death	1 Unpatient 2 UE	R/Outpatien 28b. Time of		4 🗆 1401	rsing Home 5		6 ☐Other (Spenjury occurred	ecify)
al or Attending Is after death. I Director: After d in by the funer	Certification:	1 Auatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year)	injury ne, farm, str		:? ∕es 2 □ N	28f. Locati	on (Street r Town, Str		ural Route Number,
To the Hospital or Attention 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the	Medical Cer		ysician: To the best of my know liner: On the basis of examination							
Fo the within 7 Fo the comple	Me	29b. Signature and title of certifier	1 /2 0		29c. License	number		29d. [Date signed (Mon	th, Day, Year)
- y - U		> Edward	of teelly	>	DZ	360	10	Z.	1110	4
14(30. Name and address of person who d	completed cause of death (Item	23a) (Type,	Print)	(ia MI		7100	17
n wo		11065 Little	raturent P	YWY	16010	MD	1a, M	D	2104	4
Sta	ate	31. Date filed (Month, Day, Year)	32 Aegistrar's Signatu	6						

DHMH 17 Rev 1/2001

٠			State of Maryland / Der 1- StateAmend Item #20b per fh G829 3/8/	partment of Health and Me Out tas ertificate of Death	ental Hygie	1005°	05657
	Discount of		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		JEANINE MARIETTE RULAPAUGH		FEB.17		4:30A ^M
7	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			BRADFORD OAKS NURSING HOME	CLINTON If Under 1 Year If Under 24 Hrs.		PRINCE	
Fas	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 215-54-8098 1 M 25XF 74 Yrs.	Months Days Hours Min.	B. Date of Birth (Month, Day, Ye JULY 27	ar) 1020 FD	lace (State or Foreign try) ANCE
	Director		Usual Residence of Decedent		0011 27	,1929 FR	ANCE
	yland		10a. State 10b. County 10c. City, Town or I				0d. Inside City Limits
	a-f s	ctor	MARYLAND PRINCE GEORGE	CLINTON			1 ☐ Yes 2 ☐XNo
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?
	ir death with the Marylan tams 23e or 28a-f show		7520 SURRATTS ROAD	20735		U.S.A.	
	ltam	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 1 Married 1 □ Yes 2 1 □ Yes 2 1 □ Yes	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ity Yes or No- ican, etc.)	14. Race - America Black, White, 6	
336	al', or	by F	1 ☐ Never Married 2 MX Married 1 ☐ Yes 2 MX No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: WH	ITE
5-0036	72 hours after death with the Maryland "natural", or Itams 23e or 28a-f show idical Examinat humble in Milited at	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b	. Kind of Business/Ind	lustry
2121	within 7 ene. then "r	nple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	9		
2	77 75 75 75 75		7	HOMEMAKER		OWN HOM	E
land	ed all all all all all all all all all al	To Be	17. Father's Name (First, Middle, Last) ADOLPHE JOSEPH THULIEZ	18. Mother's Name		men Sumame) MA SEMIN	EΤ
Maryland	and and is m	1 1	19a. Informant's Name/Relationship (Type, Print) ROSWELL F. RULAPAUGH-SPOUSE 810	ling Address (Street and Number or Rural			
	1 and 1 Health tem 27	-	20a Method of Disposition 20b. Place of Disp	position (Name of	1904 200	Location - City or To	wn State
Baltimore,	00-		XXSurial 2 □ Cremation 3 □ Removal from State cemetery, crew 4 □ Donation 5 □ Other (Specify) MARYLAND V	PETS • CEMETERY 7	704 20 04 C	HELTENHA	M,MD.
Balt	permit. Pag Department Important: I any injury o		21. Signature of Egheral Service Licensee MOO 179	22. Name and Address of Facility RAYMOND FUNERAL LA PLATA, MARYLA	SERVIC	E, P.A.	
			23a. Part1. Enter the disease, or complications that baused the death. Do not en shock, or heart failure. List only one cause or each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	THE CARDINA	W/De 7	KEATE	Onset and Death
1555	/Medical Examiner		resulting in death) Due to (or as a consequence of):		// //	73.	
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
$\overline{\Omega}$	ted nsit	nlne	Cause (Disease or injury				
L	be executed ician and burial-transit	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	ate be executed hysician and the burial-transit		d				
9	death certificate e attending phys od for use as the	Jedi	IF FEMALE.				
Вох	death certifica attending ph of for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of deliver	•
	the at	Physician/Medical	in the past 12 months? 1	Other (specify)		Month I	Day Year
P.0	that the de led by the a		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobacc	o use contribute to the	a cause of death?
Vital Records,	ig be	d by	Al Cheimens DISEANS	sirasiyang saass giron in rann		-1	ibly 4 □Unknown
Ö	w requ	lete			24a. Was an	24h Ware auton	ev findinge available
Re	has has	Completed			autopsy performed	prior to com death?	sy findings available apletion of cause of
ā	ician: Th certificate rector, pag	e Co	25. Was case referred to medical	26 Place of Pooth	1 Yes 2	Vo 1 ☐ Yes	2 No
>	Physician: this certific	0 8	examiner? 1 Yes Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (ont 3□ DOA Other: 4 Sursing Home		6 ☐Other (Specify)	
J Of	fing Phy I. After thi funeral (n: T	27. Manner of Death 28a. Date of Injury 28b. Time		d. Describe how in		
io	Attending r death. ector: After by the fune	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	after death after death Director:	ertification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, s building, etc. (Specify)	treet, factory, office 28	f. Location (Street City or Town, St.	and Number or Rural ate)	Route Number,
ш	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	O	29a. Certifier Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, an	d due to the cause	(s) and manner as sta	ited.
	within 24 To the Fu	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.				
	vitt To cor	-	29b. Signature and title of partifier	29c. License number	29d. (Date signed (Month, D	ray, rear)
,			· // X/	1 1 1 1 2 27 11	-	111104	
	.\	1	20 blams an address of narrow who completed seven of death (br = 20-1/7)	D/193			
	4		30. Name any odd of person who completed cause of death (Item 23a) (Type Figure 100 100 100 100 100 100 100 100 100 10	1 #103 FT. WAS	hingrans	UD 2014	14

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		-	Inpend Item# (First, Middle, Last		f,Per	ME, G\$29	#8/12/04 0 6	Death	2. Date of Dear		04 05658
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/Medical Examiner	4a. Fa	cility Name (If	not institution, give	street and number)			4b. City, Town,	or Location of D		4c. County of	
,	M∈	morial	Hospital				Cumber	land		Allega	ny
uneral	5. Soc	ial Security Nu	umber 6. Se	x 7. Ag		ast birthday)	If Under 1 Year Months Days		Min. (Month, Day,	Year)	Birthplace (State or Foreign Country)
rector		3-64-78	381	M ZUP	5 5	Yrs.			08/05/19		laryland
100	Usual 10a. S	Residence of	10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	MI		Allegan		,		umberlan	, d			1 ☐ Yes 2 🛣 No
Director		Street and Num		1 у			10f. Zip Code	14	1	0g. Citizen of Wha	at Country?
Ö		12602	N. Cresar	Street,	SW		215	502		USA	
by Funeral	1 0	arital Status	ed 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒ I If Yes, Give			Was Decedent of f Yes, specify Cul		? (Specify Yes or No- uerto Rican, etc.)		American Indian, White, etc.
pa pa	31		15. Decedent's Edu	Year or Dates:	-	16a Decer	lent's Usual Occu	nation		16b. Kind of Busin	White
Completed	Ele	(Speci mentary/Secor 12	ify only highest grad	College (1-4or 5	i+)	(Give life. I	kind of work done DO NOT use retire Greeter	during most of ed)	working	Reta	_
Be C	17. Fa		First, Middle, Last)					T	Name (First, Middle, I		
To B	Jo	hn	A l	lbert	R	oberts	on	Ruth	Eliz	abeth	Strouse
_	19a. i	nformant's Na	me/Relationship (T)	ype, Print)		19b. Mailin	g Address (Stree	t and Number o	r Rural Route Number	, City or Town, Sta	ate, Zip Code)
	Way	ne D.	Robertson	n / brothe	er	1260	0 N. Cre	sap Str	eet, SW.,	Cumberla	and, MD 21502
		fethod of Disp		Damasını fram Ctata	20b. Pl	ace of Dispo	sition (Name of natory or other pla	ace)	Date	20c. Location - Cit	ty or Town, State
.	1	☐ Burial 2.6	ົ່ງCremation 3 ∐F ຈາ⊟Other <i>(Specify)</i>	Hemoval from State		berlan	d Cremat	ory 02	2/19/2004		
once.	21. S	gnature Fur	ne al Service Licens	Celas	we	/ 22			Adams Fami reet, Cumb		mal Home, P.A. MD 21502
		Part1. Enter the shock, or hear diate Cause (t failure. List only o	lications that caused ne cause on each li	I the death	. Do not ent	er the mode of dy	ing, such as car	diac or respiratory arre	est,	Approximate Interval Between Onset and Death
ician dical niner		se or condition ing in death)	(a. Position Due to (or as							
mlner	Seque if any cause Cause	entially list cor leading to im Enter Under (Disease or i	nditions, mediate lying injury	b. Due to (or as	a consequ	ience of):					
the burial-transit	result	irtíated events ing in death) L	ast	Due to (or as	a consequ	ience of):					
	1				35,4550						
clan/M	23b. \	MALE: Was decedent n the past 12 i i Yes 2 [] Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	су		23d. Date o Month	
be d	Part II	Other signifi	icant conditions co	ntributing to death b	ut not resu	ilting in the ui	nderlying cause g	ven in Part I.			ite to the cause of death?
page 2 should									24a. Was a autops	y prio	re autopsy findings available in to completion of cause of
Com							_		perfórn 1 Ab Yes 2		tn? Yes 2□ No
Be		as case referr aminer?	-	Hassital					Death (Check only on	е)	
<u></u>	F	Yes 2 🗀	140	Hospital:	-	ER/Outpatien	1 SEN DUA		ng Home 5 Reside		(Specify)
tlon:		anner of Death Natural	5 Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	28c. Inju		1000a000a	w injury occurred	
Certification;	_		investigation 6 Could not be	2/16/04		8:41	a	Yes 2x No	wedged in v		
i ii		Homicide	determined	building, et	c. (Specify	me, rarm, str	eet, factory, office		City or Town	, State)	or Rural Route Number,
ပိ	200	Certifier	1 Costifying Phy	residence							perland,MD 21503
Medical Certifical			Medical Exam	iner: On the basis of and manner sta	examinati	ion and/or inv	estigation, in my	opinion, death o	lace, and due to the ca occurred at the time, da	ate and place, and	er as stated. I due to the cause(s)
Me	29b. S	Signature and	title of certifier					se number		9d. Date signed (A	
	1	111		111:4			OC!v	IE	F	ebruary	1/ 2004
		1 ac	colul	110-17	40						
	30. N	ame and addre	ess of person who c		eath (Item	23а) (Туре,	Print) 111 F	enn Str	eet, Balti	more, Ma	ryland 21201

State of Maryland / Department of Health and Mental Hygiene 2004 05659 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** FEBRUARY 12, 2004 4:00 P John Seideman Clarence /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S 12405 STIRRUP LANE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 1**X** M 2□ F 57 Yrs Director June 11, 1946 Washington, DC 213-44-3065 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23s or 28s-f show the Medical Expression count be notified at 1 TYes 2 □ No Bowie Director Maryland Prince Georges 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? U.S.A. Bowie 12405 Stirrup Lane by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 1 Yes 2 No
If Yes, Give X
Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Flooring 8 Floor Installer Ith and Mental Hygie 27 Is marked other r traumatic event, other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be William Harold Seideman Jessie Mae Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; if Item 27 Is any injury or other trau Sylvia Seideman/wife 12405 Stirrup Lane, Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Huntt Crematory 2/17/2004 Waldorf, Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 402 PK 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Caucer UNG Yr. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de use 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the O 9 Unknown ģ Δ. 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Diractor; the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 the 29d, Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier; 35870 no 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 14300 ballant too love #110 ECC Ver 32. Registrar's Signature 1 3 2004 State Registrar

			1 - For State Registrar	State of Man		ertificate of			giene Beg. No. 20	04 05660
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	3. Time of Death
	/Media	al	Homer H. Spivey 4a. Facility Name (If not institution, give s	tract and aumbor!		th City Tourn o	r Location of Deat	Februar	_	
*	Examir	er	Heartlands of Sev				na Park	n.	4c. County of	Arundel
	Funeral		5. Social Security Number 6. Sex	7. Age (i	n yrs. last birthday		If Under 24 Hrs Hours Min.	8. Date of Birth		9. Birthplace (State or Foreign
	Director		370-20-4337	^{M 2□ F} 93	Yrs.	Months Days	Hours Min.	Jan. 8,	1911	Alabama
	and wo		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	ocation				10d. Inside City Limits
	Mary e-f eh	to	Maryland Anne Arum	ndel	Se	everna Par	ck			1 Yes 2 No
	ith the	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
	s 23a	rail	209 St. Ives Drive				21146		USA	
õ	y within 72 hours after death with the Maryland liene. r than "netural", or Items 23a or 28e-f ehow the Medical Examinar must be rootlified at	y Funeral	1 Never Married 2 Married	2. Was Decedent Eve Armed Forces? 122 Yes 2 □ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puerl Specify:	specify Yes or No- to Rican, etc.)	14. Race Black, Specify:	- American Indian, White, etc.
12-0036	hours turei',	ed by	3XXVidowed 4 □ Divorced	Year or Dates: 1						White
Σ.	in 72 n *net	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Giv	edent's Usual Occup e kind of work done : DO NOT use retired	durina most of wo	rking	16b. Kind of Busi	iness/Industry
717	d with giene.	mo:	Elementary/Secondary (0-12)	year	F	Postal Cle	erk		US Posta	al Service
/land	be filed stal Hygid of other event, I	Be	17. Father's Name (First, Middle, Last)	l rrorr				me (First, Middle,	,	
	should by and Menta	은	John Henry Spi		40, 14,			.lda Jane		
Za	2 s a s		19a. Informant's Name/Relationship (Type Gerald S. Spivey/ S	•		ing Address (Street St. Ives				
ē,	s 1 and if Health item 27 other to		20a. Method of Disposition		20b. Place of Disp					ity or Town, State
Ē	Pages nent of ant: If it ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	1 Cemetery		04	Gotha, F	'lorida
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service License	9						neral Home
_	₫ D E e O		1994T I'UM	Co						, MD 21037
	Pnysician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Lui	ng (and a	g, such as cardiad	c or respiratory arr	est,	Approximate Interval Between Onset and Death
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	cate be executed physician and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a c	ancaduance of):					
8760,	cate be execu physician and the burial-tra	ical E		500 to (01 tis a 0	311364461106 01).					
200		g	0.							
žog	w requires that the death certifi been signed by the attending should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of a		⊒Ectopic pregnancy			23d. Date	,
	ne dea the at thed fo	ysici	1 Ves 2 No	4□Pregnant at tim 9□Unknown		Other (specify)			Month	n Day Year
<u>.</u>	that the ed by detac		Part II. Other significant conditions conf	tributing to death but n	ot resulting in the	underlying cause give	en in Part I.	23e. Did tot	pacco use contrib	ute to the cause of death?
gg	requires that the een signed by the	ed by	Chronic Obsi	ruchiv	c Puli	nonary	diseas	1 □ Ye	es 2□No 3	Probably 4 Unknown
Hecord	e law re has bee je 2 sho	piet	Preumania	7		0		24a. Was a		re autopsy findings available
	Th ate pag	Completed						perform	ned? dea	or to completion of cause of ath?]Yes 2 No
VITAI	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		at 3D DOA Othe	ar:	th (Check only on		Assisted
ō	Phys this rat di	.: To	1 Yes 2 No	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie	III SEL DON	4 🗀 Nuising 🗆	ome 5 Reside	ence 6 Cother ow injury occurred	
Vision	Attending r death. ector: After by the funer	atior	1	(Month, Day Ye	ear) Injury	Worl	k? Yes 2 □No		,,	
DIVIS	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ertification;	3 🗍 Suicide 6 🗎 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, st Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number n, State)	or Rural Route Number,
	Hospit 24 hours Funere	edical C	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of mer: On the basis of ex and manner stated	amination and/or ir	th occurred at the time envestigation, in my op	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	ause(s) and mann ate and place, and	er as stated. d due to the cause(s)
	To the within To the Youthe	Med	29b. Signature and title of certifier	and mainter stated		29c. License	number	2	9d. Date signed (i	Month, Day, Year)
	2 - 0			n	-mp	1	507	25	2-2-	- 2004
			30. Name and address of person who cor	mpleted cause of death	(Item 23a) (Type	Print) //	M111-	21/	10	2//200
			31. Date filed (Month, Day, Year)	7 901 800 32. Redistrar's	Vetera Signature	15 HWA	IVIIUI	sville	10/6/	1 01108
	Sta Registr		FEB 0 3 20	104 Jan	a A	dock				

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Larry W. February 2306 Smith 2004 /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye AUG • 30 6. Sex 11 M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Yeer) () 1950 **Funeral** Country) Maryland Months Days 53 220-56-9151 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State Show r then "netural", or items 23a or 28e-f shov The Medical Examiner mast be notified at 12 Yes 2 □ No Maryland Anne Arundel Annapolis Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21403 Apt. 1282 Graft Court death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Š 3 ☐ Widowed 4 🗹 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Anne Arundel Co. College (1-4or 5+) Elementary/Secondary (0-12) Public Works permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Importent: if Item 27 is marked other the any injury or other treumatic event, Inc. 2008. 12th Roads Operation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Cully William Smith 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Glen Burnie, Md 7846 Woodside Terrace Apt. Kimberly Smith (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Bestgate Memorial Park 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/7/04 * 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Md. 22. Name and Address of Facility
M. Reese & Sons Mortuary, P.A.
821 West St. Annapolis, Md. 21401 21. Signature of Funeral Service Licensee Jeen M00483 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical consequence of): Due to (or as Examiner 70/12 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed ofmo that initiated events resulting in death) Last and s a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial aus Medical Certification; To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dispatient 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28c. Injury at Work? 27. Manner of Death
1 ☐ Natural
2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature 29c, License number pmpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who, 7 31. Date filed (Month, Day, Year) strar's Signature State 5 2004 FEB 0 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar 05662 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February **Physician** 2004 Morton Sunderland 12:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Anne Arundel Ginger Cove Health Center Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth
Jan. 16, 1911 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** MOM 2□ F Washington 93 Yrs. 224-52-1372 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County Annapolis Anne Arundel Maryland 1 ☐ Yes 25 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 U.S.A. 2302 River Crescent Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Types 2 □ No Il Yes, Give Year or Dates: 1932–64 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 35 Married 1 ☐ Yes 2 XNo Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Naval Officer U.S. Navv 5+ 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Archibald H. Sunderland Rosie Brand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2302 River Crescent Drive Annapolis, MD 21401 Louise Sunderland/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2☐Cremation 3 ☐Removal from State 2/9/2004 Baltimore Crematory Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events the attending physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) JYes 2□No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 8 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 2□ No 2 1 No 1 Yes 1 Yes Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Hospital: 1 🗌 Inpatient 4 ☐ Horsing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA ို this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: : After Attanding Injury 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 0 To the Hospital within 24 hours a To tha Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02-09-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print bugole, led Zeos lega 1der Jackson Let 31. Date liled (Month, Day, Year) 32. Realstrar's Signature State Registrar 9 2004

DHMH 17 Rev 1/2001

ORIGINAL

Physiciar /Medica		Registrar		Cer	tificate of L)eath		Heg. No.	• • •	0566
		1. Decedent's Name (First, Middle, Last) Richard A. Snyder					2. Date of Dea Month Feb.	Day 5,	2004	3. Time of Death
Examine	al -	4a. Facility Name (If not institution, give street and Heartlands at Severn	number)		4b. City, Town, or	Location of Dea	ıth	4c. Cour	nty of Death	
LAditiiile						verna P				Arundel
Funeral Director		5. Social Security Number 199–03–8154 6. Sex 1⊠ M 2□	7. Age (In yrs. last	t birthday) Yrs.	Months Days	If Under 24 Hours Min	. (Month, Da	y, Year) 9,1915	9. Birthp Cour	place (State or Foreigntry) PA
inition at		Usual Residence of Decedent 10a. State 10b. County MD Anne Arunde		Fown or Loc	Severna	Park				10d. Inside City Limi 1 ☐ Yes 2 🛣 N
toe nu	Dire	10e. Street and Number 462 Highfield Court			10f. Zip Code 21	146		10g. Citizen o		ntry? SA
<u></u>	by Fur	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. d Forces? es 2 X No , Give or Dates:	If	Vas Decedent of His Yes, specify Cubar	spanic Origin? n, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)		ace - Americ lack, White, Wh cify:	
dical	eted	15. Decedent's Education (Specify only highest grade complete		(Give I	ent's Usual Occupa	uring most of w	orking	16b. Kind of	Business/In	dustry
r than	Completed	Elementary/Secondary (0-12) College	ge (1-4or 5+)	IIT e . L	OO NOT use retired, Truck Dr.:				Teams	ter
ed other	Be	17. Father's Name (First, Middle, Last) William Harrison Snyde	ar				_{ame (First, Middle,} Augusta		ame)	
a mark umatic	은	19a. Informant's Name/Relationship (Type, Print)			g Address (Street a	nd Number or i	Rural Route Numbe	er, City or Tow		
m 27 lu	18-	Virginia D. Snyder/Wit			Highfield	Court,	Severna	Park,		1146
ant: If Ite	0.0	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal first 4 □ Donation 5 □ Other (Specify)	om State Cem	netery, crem	en Cemete:	ry Fe	b. 9, 2004		Burni	
Departr Imports any inj		21. Signature of Juneral Service Licensee		Ba	Name and Address Arranco & 35 Gov. R	Sons,	P.A. Seve	erna Pa	rk Fu	neral Hom D 21146
	ai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Deutle a to (or as a consequen							
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ate has	Completed	Failer to	lt	100	-		24a. Was autop perfo		prior to co death?	opsy findings availa ompletion of cause
a the	ion: To Be	27. Manner of Ceath 1 Natural 5 □ Pending		R/Outpatien 8b. Time of Injury	28c. Injury Work	or: 4 Nursing	eath (Check only of Home 5 Residence 28d. Describe	dence 6 🗆 C		fy)
within 24 hours after death. To the Funeral Director: Completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 28e. F	Place of Injury - At homounding, etc. (Specify)	ne, farm, str			28f. Location (: City or Tot	Street and Nu wn, State)	mber or Run	al Route Number,
within 24 hours To the Funeral completely filled	Medical (29a. Certifier Check only one) Certifying Physician: T								
within ? To the comple	Mec	29b. Signature and title of certifier			29c. License	number		29d. Date s/g	gred (Month,	Day, Year)
		30. Name and address of person who completed	cause of death (Item 2	23a) (Type,	Print)	702	8	1/6	, 100	1 .
		ADITYA CHOPRI	A. M.D. 6 32. Resistrar's Signatur	OOK	idgelyf	ive.St	.231 Ar	MAR	LIS,	MD. 2140

DHMH 17 HeV 1/2001

Physicia		Decedent's Name (First, Middle	e, Last)							2. Date of De Month	ath Day	Year	3. Time of D
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Funeral Director		440 50 8128 Usuel Residence of Decedent	12€ M 2 □ F	7. Age (In yrs.	Yrs.			Hours	Min.	8. Date of Bir (Month, Da March	9,1950	Coun	olace (State or F otry) Sylvani
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ma 23a or 28a-f ahow r must be notified at	to	MD Balt	imore		Catonsv	7illa							1 🗌 Yes 2
r 28s	Director	10e. Street and Number	III.		Jacons	10f. Zip C	Code				10g. Citizen o	f What Cour	ntry?
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or Ita	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	Armed Fo	2 X No ve	J.S. 13.	Was Decede if Yes, specif	fy Cuban,	anic Origi Mexican, Specify:	in? (Spec Puerto R	cify Yes or No lican, etc.)		ace - Americ ack, White,	
ag ag	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t's Education		(Give	edent's Usual e kind of work DO NOT use	k done dun	on ing most o	of workin	g	16b. Kind of		
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avan	ge a	17. Father's Name (First, Middle, Robert Edward S		r.							Maiden Suma Tiedje		
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Department Important: hany injury o		21. Signature of Funeral Service		. MO104	14	2. Name and	Address of	of Facility	Harr	y H. W.	itzke's	Fami.	ly FH I MD 210
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Medical caminer	ai Examiner	disease or condition	a	Pentoba	Erbital quence of): quence of/				ardiac or	respiratory ai	rest,		Interval Between
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	Funeval		SACRED MEA 5. Social Security Number 6. S	R+ MOSI	(In yrs. la		If Under 1 Y		4 Hrs. g.	Date of Birti	h	1 LLEG 9. Birth	Plece (State or Foreign intry)	n
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	deatl	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		5. 13. Wa	as Decedent	of Hispanic Origi Cuban, Mexican,	in? (Specif	y Yes or No-	. 1	4. Rece - Amer Black, White		_
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	ro the vithin ro the complex	Me	29b. Signature and title of certifier					cense number			29d. Date	signed (Month	, Day, Year)	
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			30. Name and address of person who			-								-tradition
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 20 For State Registra 05666 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Feb. **Physician** 08^{Day} PAUL EVERETT SWANN 2004 5:23A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center La Plata Charles If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JULY 13, 1957 9. Birthplece (State or Foreign **Funeral** 1**X** M 2□ F 213-76-5615 46 Yrs. WASHINGTON, D.C. Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show retified at 10a. State 10b. County 10d. Inside City Limits 1XYes 2 No MARYLAND CHARLES LA PLATA Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? iner must be r 10550 BOX ALDER ROAD 20646 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 █XNo Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I've Ma Elementary/Secondary (0-12) College (1-4or 5+) 0 NONE NONE other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if Item 27 Is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM JUNIOR SWANN, SR. FRANCES LORENA PROCTOR SWANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANNE C. SWANN / STEP MOTHER 2315 GROUNDHOG PLACE, WALDORF, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) * 4 ☐ Donation THE HUNTT CREMATORY FEBRUARY 12,04 WALDORF, MARYLAND 21. Spature of Funeral Service Course Course MO0583 22. Name and Address of Facility
IHORNION FUNERAL HUME, P.A.
3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner din Esquentiany list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examine burial-transit death certificate be executed Due to (or as a consequence of): sician Physician/Medical thet phys use as t IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Year Day 5 Other (specify) P.O. I 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 2 1 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ R/Outpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled the Hospital Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D-22574 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20602 Robert T. Pace. 12070 Old Line Ctr Ste. 202 Waldorf MD31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 1 2 2004

			1 - For State Ragistrar	State of Maryla	and / Depa <i>Cei</i>	artment of H rtificate of I	lealth and N Death	fental Hygi Ra	iene 200	05667	
			Decedent's Name (First, Middle, Last	st)				2. Date of Death	1	3. Time of Death	
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			Garrett County M			Oaklar			Garrett		
	Funeral Director		5. Social Security Number 6. S 099129499	ex 7. Age (In y	rs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 31,	Year) (rthplace (State or Foreign country) W York	
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	with the or	2	8 Kudyba Court				7726		US.		
	Jeath	Funeral	11. Marital Status	12. Was Decedent Ever in		Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Am	erican Indian,	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23a or 28a-f show eumatic event, Its Madical Examinet nust be neithed at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: W		lf Yes, sp <i>e</i> cify Cuba 1 □ Yes 2 🗓 No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	ite, etc. White	
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	as 1 and 2 should b of Haalth and Meniz f item 27 is markad r other treumatic e		20a. Method of Disposition		. Place of Dispo	lyba Court			Oc. Location - City o	07726 r Town, State	
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altimore,	permit. Pages 1 Deportment of H Importent: If ite any injury or ot		21. Signature of Funeral Service Licen	Α	Cremato	2. Name and Addres			neral Home		
ä	Deprint Import		> Buller 1	Dion	3	2 S. Seco			Maryland	21550	
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<u>></u>	lor A after Dirac Jin by	Certification:	4 Homicide determined	building, etc. (Spe	cify)	eet, factory, office		City or Town,		oral Fronto Mombol,	
	spite nerel			ysician: To the best of my l							
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	To the To the Comp	Ž	29b. Signature and title of certifier		_	29c. License		29	d. Date signed (Mon		
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State of Maryland / Department of Health and Mental Hygiene 2004 05668 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2004 0230 M Ε. Stull1 Jean INVUNDU /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner RegiONNI CONTY PININSULA Medical 54115641 WIRDMICO If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Feb. 27, 1928 Pennsylvania **Funeral** Min Months Davs Hours 1 ☐ M 2 ☐ F 75 190-22-5476 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location ? is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 10d. Inside City Limits Federalsburg MD Caroline 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 21632 115 West Central Avenue United States death 1 by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼ No Specify: 3℃Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tri-Gas & Oil Co. Executive Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of John McIntire Nellie Freida Vaughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 :
Department of Health ar
Important: If item 27 is
eny injury or other trau Laurie Schmitt/Daughter 115 W. Central Ave., Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State E. Shore Vet.Cem.2/3/04 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility $Framptom\ Funeral\ Home,\ P.A.$ 21. Signature of Funeral Service Licensee Michael 7-Esken 216 N. Main St., Federalsburg, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) adure con resture recont Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day signed by the att 4 Pregnant at time of death 5 Other (specify) □Yes 2□No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part It. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Munci Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performed? vasculin dinear sim 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 0 No Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Hnpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospitel or Attending 5 Pending investigation 1 Naturat after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funerel L 1 Defritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 0 albenneh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mD 1346 SALISBURY RODINEY S. DIVISION ST. WENRICH 31. Date filed (Month, Day, Year) 32. Registrar's Şignature State Registrar

,			1 - State of Maryland State of Maryland	/ Depa	rtment of H tificate of L	ealth and Death		giene Reg. No.	200	14	05669
	Dhusiai		Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Dey	Ye	ar	3. Time of Death
	Physicia /Medic		SHIRLEY MAE STONESTREET				FEB.		2004		10:02P ^M
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	_ 8		CIVISTA MEDICAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last	st hirthday)	LAPLA If Under 1 Year	ATA If Under 24 Hi	rs. 8. Date of Bir	th	CHARL		ce (State or Foreign
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	ryland how		10a. State 10b. County 10c. City, T	Town or Lo	cation					10d	I. Inside City Limits
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<u>8</u>	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print) CYNTHIA LESTER-DAUGHTER		DOGWOOD						
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	4		30. Name and addr as of person who completed druse of death (Item 2)	.3a) (Type,	Print)						
	U		ASHVINKUMAR J. PATEL MD 102		IL MELLO	N CT S	UITE 10	2 W	ALDOI	RF,M	ID20602
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signatur FEB 2 3 2004	ie A	Acortic?						

DHMH 17 Rev 1/2001

SHIRLEY STONESTREET

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 05670 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Day Month Year **Physician** 10:35 PM February 2004 TODD Μ. /Medical HILDA 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Crisfield Somerset 20 Maryland Avenue If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months 1 M 2 XF Yrs. 88 September 4, 1915 Maryland 218-36-7714 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State Show "natural", or Items 23s or 28s-f shov 1 ☑ Yes 2 ☐ No Crisfield Directo Maryland Somerset 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 21817 20 Maryland Avenue filed within 72 hours after death Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No White Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 Divorced al Hygiene. Jother then "nature went, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 12 Deputy Comptroller 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental P Peges 1 and 2 should be 1 nent of Health and Mental I ant: If Item 27 Is marked o Bessie W. Parks Clarence T. Todd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Casey Todd (Executor of Estate) P.O. Box 671, Crisfield, Maryland 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department o Important: If any injury or pnce. 2/20/04 Sunnvridae Memorial Park Crisfield, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funer Service License Bradshaw & Sons Funeral Home Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfie 33a. Pertl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, Maryland 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCVD **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit physician and The law requires that the death certificate be exec Due to (or as a consequence of): P.O. Box 68766 Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 1 Yes 2 No certificate or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) examiner? Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Ailer Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 48098 February 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. - 201 Hall Highway - Crisfield, Maryland 21817 Vijay Karumbunathan, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Co.

		Certificate of Death	2. Date of De	Reg. No.		05671
Physic /Medi		1. Decedent's Name (First, Middle, Last) HELEN MADELENE THOMPSON	FEB • 1	O, 2004	Year	Time of Death 6:20PM
Exami	ner	, take the same to	Location of Deati		of Death	S
Funeral Director		5. Social Security Number 577-20-3614 6. Sex 1 Months 1 M		y, Year) 1,1916	9. Birthplace Country) VIRGII	(State or Foreign NIA
aryland show	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MARYLAND CHARLES WALDORF				nside City Limits
h with the M 3e or 28e-f	Funeral Director	10e. Street and Number 4140 OLD WASHINGTON ROAD 20602		10g. Citizen of V	What Country?	K
hours after death with the Maryland hours after death with the Maryland tural', or itema 23e or 28e-f show at Examiner must be notified at	by Funer	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Ves 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Rad Blad Specify	ce - American Inck, White, etc.	
d 2 should be filed within 72 hours af the and Mental Hygiene. 7 Is marked other than "netural", or traumatic event, the Medical Exam.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work done	orking		usiness/Industr	<i>y</i>
d be filed vintal Hygie	Be	17. Father's Name (First, Middle, Last) 18. Mother's Na	ame <i>(First, Middl</i> e,	Maiden Suman	•	
d 2 should th and Men 7 is marke traumatic	To	19a. Informant's Name/Relationship (Type, Print) PHYLLIS SOMERS-DAUGHTER 19b. Mailing Address (Street and Number or F 9710 FAITH BAPTIS	Rural Route Numbe	er, City or Town,	State, Zip Cod WHITE	PLAINS
permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date 2 – 13 – 04	20c. Location -	BURG,	
402 % 0		23a. Part 1. Enter the disease, or complications that caused the death. Sonot enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.			App	roximate rval Between
Physician Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE ALEART Due to (or as a consequence of): CARDIAC ARMTH 10		LURE	Ons	eet and Death
certificate be executed uding physician and use as the burial-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of):	*> A			
that the death cert ed by the attendin detached for use	Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did	obacco usa co	ntributa to tha	causa of death?
es that the igned by t be detach	by Phy	ATHEROSCHLEROFFI VASCULAR DIJEAD	È 10	Yas 2□ No	3 ☐ Probably	4 Unknow
requir been si should	Completed b		24a. Was perfo	an autopsy med?	available	utopsy findings e prior to tion of cause 1?
The ate h page			101	es 2 No	1 □ Yes	s 2□ No
Physician: The this certificate rail director, pag	To Be	examiner? 1 Yes 2 SNo	eath <i>(Check only o</i> Home 5 ☐ Resid		er (Specify)	
th. :: After the function	ation:	27. Manner of Death Squatural 5 Pending 2 Accident Accident Pending 2 Accident Accident Pending 2 Accident Pending 2 Accident Acci	28d. Describe I	now injury occur	red	
To the Hospital or Attending Physi within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (5 City or Tox	Street and Numb m, State)	er or Rural Rou	ite Number,
Hospit 24 hour Funers etely fills	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.				
To the within To the comple	Me	29b. Signatur and title of certifier 29c. License number		29d. Date signed		
6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print). ASHVINKUMAR J PAPEL 10 2 PAUL METION	CT WA	(DORF	MD 2	0602
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 16 Rev 6/95

		•	1 - For State Registrar	State of Maryland / D	epartment of H Certificate of I	lealth and M Death	lental Hygi	ene 2004	05672
			1. Decedent's Name (First, Middle, Last)	f t			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Joan E.	Vernette	-		2	Co 200 4	0230 M
	Examin Funeral		4a. Facility Name (If not institution, give s COLD 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	eday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,	4c. County of Death	a J
	Director		701-10-0710	65 Y	rs.		7/31/	7/38 Mi	ssouri
	death with the Maryland ime 23e or 28e-f ehow rmust be notified at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location Umbig				10d. Inside City Limits
	or 28e-	Funeral Director	10e. Street and Number	C C	10f. Zip Code	0	10	g. Citizen of What Cou	intry?
	ne 23e	erail	6049 Shept	had Square 12. Was Decedent Ever in U.S.	13. Was Decedent of H	ispanic Origin? (Spe	ecify Yes or No-	14. Race - Ameri	can Indian,
336	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or iteme 23e or 28e-f ehow or other treumatic event, Ite Medical Examiner man be notified.	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	sn', Mexican', Puèrto Specify:	Rican, etc.)	Black, White	where
21215-0036	n 72 ho	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	durina most of worki	ng 1	6b. Kind of Business/Ir	ndustry
212	filed within Hygiene. other than "	omo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Salesperson	*	!	Retail	
	be filed ital Hygi id other event, I	Be	17. Father's Name (First, Middle, Last) Charles Frederick	Foronborgor		18. Mother's Name		aiden Sumame)	
Maryland	should but and Ment marked	ဥ	19a. Informant's Name/Relationship (Type		Mailing Address (Street	Marie Ger		City or Town State Zi	n Code)
	1 and 2 sho Health and em 27 is m		John K. Vermette/H		19 Shepherd				o code,
Baltimore,	of He of He or other		20a. Method of Disposition 1 ☐ Burial 2 ☼ Cremation 3 ☐ R	20b. Place of I	Disposition (Name of crematory or other place	(6)	ate 2	0c. Location - City or T	own, State
Ħ	Part for		`4 □Donation 5 □ Other (Specify)	Metro	Crematory	2-6-2		Catonsville	·
Ba	permit. Departr Importe any nji		21. Signature of Funeral Service License	- milki	4112 Old Co	olumbia Pi	ke Ellic	cott City,	
	Physician		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death. Do not be cause on each line.	ot enter the mode of dyin $3l\omega_{ m D}$	g, such as cardiac o	r respiratory arres	St,	Approximate Interval Between Onset and Death
\$ \$	/Medical Examiner		resulting in death)	Due to (or as a consequence of VASCUL, UK):				luck
	P E	Iner	Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury	Dual to (or as a consequence of					la u
~	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	10 JYNDOU.	me			Om icti
8760,	ate be hysicia the bur	dicai	d						
9	eath certific attending pl		IF FEMALE:	3c. If yes, outcome of pregnancy				23d Date of dollar	0.54
.O. Box	that the death ed by the atten detached for u	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □ Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliv Month	Day Year
ds, P	Se un equ		Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause give	en in Part I.		acco use contribute to t	he cause of death?
Records,	The iaw requirate has been sipage 2 should	Completed					24a. Was an autopsy perform	prior to co death?	opsy findings available impletion of cause of
Vital		BeC	25. Was case referred to medical			26. Place of Death		De No 1 ☐ Yes	2 No
	Physician: this certificant	2	1 195 58 140	ospital: 1 Inpatient 24 ER/Outp		4 Nursing Hor		ce 6 Other (Specia	(y)
Ou	Jing After fune	tion:	27. Manner of Death 1 ■ Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tir	ury Worl	/ at <br Yes 2 □ No	28d. Describe how	vinjury occurred	
Division of	if or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	-	28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Phys	sician: To the best of my knowledge, her: On the basis of examination and and manner stated.	death occurred at the tim for investigation, in my of	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as s e and place, and due to	tated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	11/	29c. License			d. Date signed (Month,	
/	(D)		1/4/2 les/	we touted mus	D38	300		L-6-01	4
(Sub		30. Name and address of person who co Hicholas Routzelak	mpleted cause of death (Item 23a) (T	ype, Print) TUKCUT PK	, Cepun	bis mi	2-6-01 D 21044	
Ġ	Sta Registr		31. Date filed (Month Day, Year) 2004	2. Registrar's Signature	berte	,		*	

DHMH 17 Rev 1/2001

Robert W. Ward 04 - 1081**AKG** For

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hy

/giene	2	0	0	4	0	5	6	7	
Reg No.	-	_	•		0	U	J		

3

			Registrar		Certificate of Dea	ath	Reg. No.	00010
			1. Decedent's Name (First, Middle,	Last)		2. Date of De	aath	3. Time of Death
	Physic /Medi		Robert William	Ward		Month Febru	Day Year lary 8, 2004	3:06 P M
	Exami		4a. Fecility Name (If not institution,	rive street and number)	4b. City, Town, or Local		4c. County of Death	1 3.00 I
			726 Second Stre	et	Annapolis		Anne A	nindel
	Funeral		Social Security Number	Sex 7. Age (In yrs. last bi		Inder 24 Hrs. 8 Date of Bir	th 0 Biths	lace (State or Foreign
	Director		219-88-6917 Usuel Residence of Decedent	1 ® M 2□ F 37	Yrs. Worthis Days Hot	ours Min. (Month, De June 2	28, 1966 Wash	ington, DC
	with the Maryland a or 28a-f show	_	10a. State 10b. County	10c. City, Tow	n or Location		1	0d. Inside City Limits
	8a-1	Director		Arundel Annap	olis			1 ☐ Yes 2 No
	or 2	Dire	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cour	ntry?
	€ 23		3225 Black Waln	ut Drive	21403		United Stat	ces
	ter dea Itams Def ou	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanio If Yes, specify Cuban, Mer 	ic Origin? (Specify Yes or No exican, Puerto Rican, etc.)	14. Race - Americ Black, White,	
36	urs after o al', or Itar Exeminer	by Fi	1 Never Married 2 Married	If Yes, Give	1 ☐ Yes 2 ♣ No Spe		Specify:	oto.
Maryland 21215-0036		q p	3 Widowed 4 Divorced	Year or Dates: 1989			whi	ite
5	n 72 ho natur	Completed	15. Decedent's (Specify only highest)	Education 16a trade completed)	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	most of working	16b. Kind of Business/Inc	dustry
12	d within giene. r than "	E .	Elementary/Secondary (0-12)	College (1-4or 5+)				
2		ပိ	17. Father's Name (First, Middle, La	4	accountant	dahada birana (mina dari (d	accounting	
ano	9 7 5	Be		PI/		Mother's Name (First, Middle,	,	
Ž	should be nd Mental marked umatic av	T ₀	John Ward	T		atherine Riley	·	
Z	12 st h and 7 Is n		19a. Informant's Name/Relationship		. Mailing Address (Street and Nu			
	os 1 and 2 should by Health and Ment item 27 Is marked other traumatic e		Andrea White/ C		104 Bradley Bl f Disposition (Name of			
Ö	<u> </u>		1 ☐ Burial 2 🛍 Cremation 3	☐Removal from State cemete	ry, crematory or other place)	Date	20c. Location - City or To	wn, State
ţij	mit. Pages partment of cortant: If it injury or o	1	*4 □Donation 5 □ Other (Spe	TICCLO	politan Cremato		Alexandria,	
Baltimore,	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Lic	ensee	22. Name and Address of Fa	acility John M. Ta	aylor Funeral	Home, Inc
	40260		12. Sega	Kememoli		Gloucester St.		MD 21401
	Physician /Medical Examiner	ıer	Sequentially list conditions, ray leading modern modern cause. Enter Underlying Cause, Disease or injury	a. Contact gue Due to (or as a consequence) Due to (or as a consequence)	shot would to		A .	Interval Between Onset and Death
68760,	certificate be executed nding physician and use as the burial-transit	n/Medical Examiner	cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	c	of):			
P.O. Box	res that the death certi igned by the attending be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver	ry Day Year
	gned gned	by P	Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause given in Pa	art I. 23e. Did to	bacco use contribute to the	e cause of death?
ord	w requires been sign should be	ted 1				1 D Y	′es 2 ⊠ No 3⊟Proba	ably 4 □Unknown
al Records,	The law rate has be page 2 sh	Completed				24a. Was a autop perfor	sy prior to com med? death?	sy findings available ipletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		lace of Death (Check only or	18)	
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Division	ling After fune	Certification:	1 Natural 5 Pending 2 Accident Investigati	(Month, Day Year) II	ime of 28c. Injury at piury Work? My 1 Yes 2	20000000	owinjury occurred a Sket self	
<u>×</u>	Atte octo by th	iţic	3√ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury - At home, fa		28f. Location (S	treet and Number or Rural	Route Number, i
O	al or s afte of in	Sert	- Citionione		-Cice	City or Tow	n. State) East port	Yacht Cab
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely lilled in by the	Medical C	29a. Certifier 1 Certifying F (Check only one) 1 Medical Ext	hysician: To the best of my knowledge miner: On the basis of examination and	death occurred at the time, date	e and place, and due to the e	outed(a) and manner on the	lad .
	thin ;	Mec	29b. Signature and title/of certifier	and manner stated.				
h.	7. × 2. 8			/ ///	29c. License numbe	2	9d. Date signed (Month, D	ay, rear)

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S.R. HOGAY 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

February 9, 2004

State Registrar

FEB 1 1 2004



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1 - For State Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death

ł	0567	L
	3 Time of Death	

Physician /Medical Examiner

Helen Jean Whitlow 4a. Fecility Name (If not institution, give street and number) Carroll Hospital Center

1. Decedent's Name (First, Middle, Last)

4b. City, Town, or Location of Death Westminster

7 05, 2004 1852 P M 4c. County of Death

Funeral Director

the Medical Examiner must be notified at

Items

6

natural

other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or othar traumatic event gone.

Physician

/Medical

Examiner

and

physician

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After

Director: /

within 24 hours at To the Funeral Di completely filled in

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4

death.

9

page certificate

director,

the burial-

ast attending p for use as

The law requires that the death certificate be executed

or Attending Physician:

To the Hospital

Box 68760.

P.O.

of Vital Records,

Division

Examine

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

235**-**46**-**5659 Usual Residence of Decedent 10a, State 10b, County

5. Social Security Number

Yrs. 10c. City, Town or Location

7. Age (In yrs. last birthday)

73

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | Min. | March 14, 1930

2. Date of Death

February 1

 Birthplece (State or Foreign Country) W.VA

10d. Inside City Limits

with the Maryland 23a or 28a-f show

Direct

Funeral

by

Completed

MD

Carroll

1 M 2 TF

Sykesville

10f. Zip Code

1 ☐ Yes 2 ☑ No

1 ☐ Yes 2 XNo

White

10e. Street and Number

3736 Sykesville Road 11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:

21784 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify

USA 14. Race - American Indian, Black, White, etc.

10g. Citizen of What Country?

Specify.

Carroll

1 Never Married 2 Married 3 Widowed 4 Divorced

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

12 17. Father's Name (First, Middle, Last)

Elementary/Secondary (0-12)

Manager

Admiral Dry Cleaners 18. Mother's Name (First, Middle, Maiden Sumame)

Alvie Smith

19a. Informant's Name/Relationship (Type, Print)

Eva Mae Squires 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Lynn Crouch/daughter

3429 Viewridge Circle Manchester, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify)

Lake View Memorial Pk 2/10/2004 Sykesville, MD

21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Fritts funerally Home and Chapel, P.A. Westminster, MD 412 Washington Road

21157 Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Pul monary Due to (or as a consequence of):

Fractived Due to (or as a consequence of)

tal

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

4☐Pregnant at time of death 9 Unknown

23e. Did tobacco use contribute to the cause of death? 2 XNo 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 2 No

24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 No

1 X Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner? XX Yes 2 □ No

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Thomicide

28a. Date of Injury (Month, Day Year) 5 Pending 2-4-4 investigation 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

28b. Time of UNK

Hospital: XXX Inpatient 2 EP/Outpatient 3 DOA

drivewan

28c. Injury at Work? 1 ☐ Yes 2 No

1 Certifying Physician: To the best of my known ge, a ath occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred Deceased Sell

28f. Location (Street and Number or Aural Route Number, City or Town, State) Sylves ville Rocad Sylves ville, MD 21781

29a, Certifier

2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2x Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

February 06, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOGAI R. 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

FEB 0 9 2004

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 05675 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Emma Lee Lawson Winzerwrith February 3, 2004 11:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 1280 Graff Court Apt. Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year)
Aug. 22, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☑ F Months Virginia Director 223-46-7799 83 1920 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other treumatic event, Ite Medical Examinat man be nutitied at once. 10a. State 10b. County Maryland Anne Arundel Annapolis 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 U.S.A. 1280 Graff Court Apt. 2D Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes . ② No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2000 Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edgar Johnson Robert Nathan Grimsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 78 Willowbrook Drive Ronie Lawson/son Pasadena, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition NSBurial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 2/6/2004 Annapolis, MD 4 □ Donation 5 □ Other (Specify) 21. Signa Language License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COMPLETE HEART **Physician** /Medical Due to (or as a consequence of): Examiner CARDION YOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner - Biventricular Heart Failure the death certificate be executed use as the burial-transit Due to (or as a consequence of) O. Box 68760, attending physician FIBROSIS IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ξ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) detached þ ۵ been signed be should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð of Vital Records, 3 Probably 4 □Unknown MELLITUS 2 No Be Completed ARTERIEL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 1 Yes 2 No or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of D ath 28b. Time of 28d. Describe how injury occurred After Injury Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2003 Medical Phway 8th 100 ANNAPOULS: MD ANDREW GOLDON MD 31. Date filed (Month, Day, Year) 32. Restrar's Signature State 5 Registrar

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last)

1 - For Stete Registrar

Division of Vital Records, P.O. Box 68760,

		1. Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
Physici /Medio		Guy	Whitson				Februs		1 2 4 7 7 V V 2 4 4
Examin		4a. Facility Name (If hot institution, give			4b. City, Town, o	r Location of Deat		4c. County of	
			pital Cente		Kills doed Wass	Me stmi			arroll
Funeral Director		5. Social Security Number 6. Several Security Se	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1930 NC	Birthplace (State or Foreign Country) PRTH CAROLIN
ms 23a or 28a-f show		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
is b	ţoţ	MD. CARROLI	. M	ESTMI	NSTER				1 ☐ Yes 2 No
r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
23a	alD	618 DORIS AVE.			2115	7		USA	
ems er m	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	P	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - Black.	American Indian, White, etc.
"natural", or items 23a or 28a-f show idical Examinar must be notified al	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 No 194 If Yes, Give Year or Dates: 194	18	I□Yes 2⊠ No	Specify:			WHITE
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then he M	To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired UPERVIS	•		GAS & E	LECTRIC
Department or reading an when they believe important: If item 27 is marked other then eny injury or other traumatic event, the Ma 0008.		17. Father's Name (First, Middle, Last) SA	M WHIT	rson		18. Mother's Na		Maiden Sumame) BOWMAN	
mark	ř	19a. Informant's Name/Relationship (Ty	ое, Print)	19b. Mailin	g Address (Street	and Number or Ri	ural Route Numbe	er, City or Town, Sta	ite, Zip Code)
27 is r tra	ij	SHIRLEY Z. WHITS	SON - WIFE	618	DORIS A	VE., WE	STMINS	TER, MD.	21157
nt: If item ry or othe	000000000000000000000000000000000000000	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Z ION	Place of Disposemetery, crent	sition (Name of natory or other place CHURCH	CEM. 2	Date / 9 / 0 4	20c. Location - Cit	y or Town, State
portal y inju	İ	2 Signutury of Funeral Solvice License						FUNERA	L HOME
E 9 9		KAUSU THE						INSTER,	MD. 21157
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sician	6	Immediate Cause (Final disease or condition resulting in death)	RENA	L FA	HCUKE VE HE OLIFER	-			Onset and Death 4 CKS
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ysicia ne bur	cal								
ing ph e as th	Med	IF FEMALE:							
the attending p	sician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
been signed by the should be detached	Physic	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	iderlying cause give	en in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
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shou	Completed						24a. Was	an 24b. Wer	e autopsy findings available
age 2	шо							rmed? deal	to completion of cause of the
tor, p	Be C	25. Was case referred to medical			-	26. Place of Dea	ath (Check only o		165 Z Z 110
direc	To 8	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 patient 2	ER/Outpatient	t 3□ DOA Othe	er: 4 🗆 Nursing H	lome 5 ☐ Resid	dence 6 □Other (Specify)
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he fu	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1□'	Yes 2 □ No			
4 Homicide determined building, etc. (Specify) 28. Clay or Town, State)									or Rural Route Number,
e Funer letely fill	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the timestigation, in my or	ne, date and place pinion, death occu	e, and due to the irred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
comp	ž	29b. Signature and title of certifier	1 1 20		29c. License		_	29d. Date signed (N	fonth, Day, Year)
12		K	distribution of	MO		7 PPZ COC	3	Rebrusry	5,2004
HVA		30. Name and address of person who co		23a) (Type, I	Print)				
1 1 "		John C. Abel, Mo		ner Ave	e. Suite	307	Mostu.	oster, MK	21157
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	1 .				
Registr		FEB 0 9	2004 Jelen	D. A	30246				
7 Rev 1/20	101				,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2004

05676

State of Maryland / Department of Health and Mental Hygiene 2004 05677 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Johanna A. Wojcicki Jan. 2004 11:15 p^M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Retirement Community Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 137-14-8492 1 ☐ M 2X F 83 Director Sept. 12,1920 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow ral', or Itama 23a or 28a-f ahov Examiner must be notified at MD 1 ☐ Yes 2 ☐ No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane 21228 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: Specify Completed by 3 Widowed 4 Divorced "natural", er than "nature". The Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.
T 27 Is marked other than "virtraumatic aven." Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Budrecki Anna Nevers ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Fran Bauer/Daughter 1270 Fenwick Garth, Arnold, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Removal from State 2 ☐ Cremation 3 ☐ Removal from State Feb. 3/4 MD Veterans Cemetery ` 4 ☐Donation _ 5 ☐ Other (Specify) Crownsville. MD 21. Signature of Firmeral Service Licenses 22. Name and Address of Facility Barranco & Sons Barranco & Sons, P.A. Severna Park Funera 495 Gov. Ritchie Hwy, Severna Park, MD 2 234-Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscleratic **Physician** /Medical Due to (or as a consequence of) Examiner superitally list sundations if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trans Due to (or as a consequence of) Box 68760. physician Completed by Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year signed by the at d be detached fo 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown cancer 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate 1 Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1. Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 🗌 Yes 2 No s after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D 30989 address of person who completed cause of death (Item 23a) (Type, Print) 711 Maiden Choice Ln Catonsville penter 31. Day State 5 FEB 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05678 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 4, WEST 2004 6:05 AM LUCY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cheverly Prince Georges Prince Georges Hospital Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. | May 15, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 □ XF 89 1914 Virginia 579-26-2015 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State ral', or Iteme 23s or 28s-f show Examiner russ be notified at 1 Yes 2 No Maryland Prince Georges Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20720 U.S.A. 12311 Thompson Road Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No ff Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White natural, or 1 ☐ Yes 2 X No Specify: þ 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Soda Fountain Clerk Food Service 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Maria Shelton Ε. Brawner James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12311 Thompson Road, Bowie, Maryland 20720 Evelyn M. Still/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
eny injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National Cemetery 2/6/2004 Suitland, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Syndrome Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause to account injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events the attending physicien and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant al time of death Day in the past 12 months? Month Year 5 Other (specify) signed by the a ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Cerebrovasulor Disease Completed been : Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No this After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funerel Director: in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D39550 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) · Hajjar, J. M. D. 4850 Forbes Blud Lanham, Md. 20706 George C 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 5 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene = For State Registrar 05679 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Laura Alida Williamson 1215 Feb. 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Dorchester 7236 Hynson Road Hurlock If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ ★F 67 14,1936 Maryland **Director** 220-32-8320 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits worle 10a. State 10b. County me 23a or 28a-f ehov 1 ☐ Yes 2 No Completed by Funeral Director Dorchester Hurlock 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number death with 7236 Hynson Road 21643 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. the Medical Examiner filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 🙀 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) aith and Mental Hygiene. 27 is marked other then "I r traumatic event, the Mac Elementary/Secondary (0-12) 12 College (1-4or 5+) Sewing Factories Seamstress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Raymond Cole Susan Chloe Cole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 other tra Keith Williamson/Son 7236 Hynson Rd., Hurlock, MD 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hillcrest Cemetery2/7/04 Federalsburg, MD 22 Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee Mulay LARIN 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a drenal 346 etastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, cading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2184No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification; > Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DWD 14/04 D0053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bloomingdale Are FederalsburgMO 21632 315 Melinda 31. Date filed (Month, Day, Year) 32. Registrar's Signature Jan Barrell att of the

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Registrar

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	Physici /Medic	al	Decedent's Name (First, Middle, John	R.		insor			2. Date of De Month	Day	Yeer OH ty of Deeth	3. Time of Death
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980	hours after death with the Maryland turel; or Iteme 23e or 28e-f ahow at Exeminar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces d	?		Was Decedent of His f Yes, specify Cubar I Yes 2 No	panic Origin , Mexican, Specify:	n? (Specify Yes or No Puerto Rican, etc.)	Bi	ace - America ack, White, e ify: White	etc.
Maryland 21215-0036	within 72 ane. than "na:	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	F.\	(Give lite. L	dent's Usual Occupa kind of work done di DO NOT use retired) Sing Direc	uring most o	of working	16b. Kind of I		·
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Baltimore,	of Her		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		St. Ma	ary's C	sition (Name of natory or other place emetery		Date 2/17/2004	20c. Location		wn, State MD
Balt	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Li	censee AAA	'u'	22	Nan Searpelli 108 Virgi		al Home, PA enue: Cumber	land, MD	21502	
7602	And the burial-transit the buria	dical Examiner	23a. Part1. Entir the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SEAS Due to (or as b. LEFF Due to (or as	ine. 15 s a consequen	ce of): UEV			ZUMON1		0	Approximate Interval Between Onset and Death ONE DAY
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	uires that signed b	þ	Part II. Other significant condition	s contributing to death	out not resultin	ig in the ur	nderlying cause give	n in Part I.		obacco use cor Yes 2 X No		e cause of death?
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	To the Hospital o within 24 hours aff To the Funeral Di completely filled in	Medicai	(Check only 2 Medicel E:	Physician: To the best caminer: On the basis of and manner s	of examination	dge, death and/or inv	estigation, in my opi	nion, death	occurred at the time,	date and place	, and due to	the cause(s)
	Mith con	2	29b. Signature and title of certifier 30. Name and address of person w	and	New death (Item 23	a) (Type)	29c. License	number 486°	_	FEB .	TU	2004_
	Sta Registr		31. Date filed (Month, Day, Year)		500 rar's Signature		miorial)	Ore 1	Cumberle	ind , VAC	(21:	502
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State of Maryland / Department of Health and Mental Hygiene 05681 State
Registrar Amend Item#2" perPHYG8282/21/04 EW Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Lewis Harry Walker January 25, 2004 /Medical 6:30 a 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2249 Engle Road Harford <u>Fallston</u> 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Months 219-12-5223 78 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-1 show the Medical Examener must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2249 Engle Road 21047 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married 1 XYes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ If Yes, Give Year or Dates: WW II Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State Highway Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Administration permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygle. Important: If item 27 is marked other to any injury or other traumatic avant. The once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Melvin Walker Anna Tracey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary B. Walker/Wife 2249 Engle Rd., Fallston, MD 21047 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 1 □ Burial 2 MCremation 3 □ Removal from State York, PA *4 ☐ Donation 5 ☐ Other (Specify) Cremation Service 2004 21- Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA Reaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 17349 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 40 cardia /Medical Due to (ar as a consequence of) Examiner 110 Vascular InTeriosclero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ete has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To To the Hospital or Attanding Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Name and address of ers v o completed cause of death (Item 23a) Type, Print) Air, W.D. 31. Date filed (Month, Day, ec 32. Registro's Signature State 1 2004 Registrar

		1	For State Registrar	State of Ma	aryland	d / Depa	artment of F	lealth and Death	d Mental Hy	giene Reg. No. 20	04	05682
3	dica		Decedent's Name (First, Middle, L Robert Lee Ande	erson			4b. City, Town, o	r Location of D	2. Date of De Month Februa	Day	Year 2004	3. Time of Death 9:58AM
Exar Funer Direct		5			e (In yrs. la	est <i>birthday)</i> Yrs.	Baltimo	ore If Under 24 I	Hrs. 8. Date of Bir Vin. (Month, Da	N/A	9. Birthp	olece (State or Foreign ntry) y land
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with the M 3a or 28a-f	Cineral Director	1	MD N/A 0e. Street and Number 5007 Oakland Av		Bal	timor	e 10f. Zip Code 21206			10g. Citizen of V		X itry?
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_ > . 9	1116	2	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	Hospital: 1 Inpatie 28a. Date of Inju. (Month, Date)	ry	R/Outpatier 28b. Time of Injury	Wor	ner: 4 ☐ Nursin	Death (Check only ong Home 5 Residue) 28d. Describe			()
DIVISION vitel or Attending urs after death. real Director: Afte			3 Suicide 6 Could not determine	d 286. Flace of Injury	c."(Specify,)	eet, factory, office		City or To			
TO the Hospitel or Attending Physicial 24 hours after death. To the Funeral Director: Attent completely filled in by the funeral		200		hysician: To the best of aminar: On the basis of and manner sta	examinati			opinion, death o			and due to	the cause(s)
6			30. Name and address of person wh	completed cause of d	leath (Item	23a) (Type,	Print Selve	462	67 Aux#3	923 OV Ba	10 C	LOG UIX
	State istra	7	31. Date filed (Month, Day, Year)	32 Registra	ar's Signat	ure do	odí		7,000			,,,,,,

DHMH 17 Rev 1/2001

Known As: Andurson, hoberit

State of Maryland / Department of Health and Mental Hygiene 2004 05683 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Alton 2320 M pordon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner seneral situl betweeter asrol H19 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct 2.8 192 0512 unti Birthplace (State or Foreign Country)
 NY 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X**□M 2□F 82 047-18-9394 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinar must be notified as ARG. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Sykesville Md Carroll 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 USA 7200 Third Avenue Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status I TYPes 2 No WWTI
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) teacher education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ethel M. Diver John Alton ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1429 Fairmount Rd., Hampstead, Md 21074 Yong Alton (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) All County Cremation 2-24-04 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ Jaight Height Jerbert P.O. Box 195 Sykesville, Md 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumon.a al disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Myscardial Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or s a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ρģ in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐Unknown 1 Yes 2 No Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 this certificate 1 Yes 1 ☐ Yes 20/No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 1 ☐ Yes 2 No 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1) Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after within 24 hours a To the Funeral (the Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of gentifier MO n 30. Name and address of person completed callse of death (Item 23a) (Type, Print) 307 Westminster 31. Date filed (Month, Day, Year) 14000 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 05684 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 9:55 Hrnold W. February 21 2004 homes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner larro 11 m+ Aice Pleasant View Nursing Home If Under 1 Year of Under 24 Hrs. 8. Date of Birth (Month Day ADTII 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Min. Days Hours Months 100 M 2□F 90 213-14-3103 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercitivatives be notified at any injury or other traumatic event, the Medical Exercitivatives be notified at another. 10a. State 10b. County Md Sykesville 1 ☐ Yes 2 ☐ No Carroll Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 USA 2711 Old Liberty Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No WWIII If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 TWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Calvert Distillary Elementary/Secondary (0-12) College (1-4or 5+) warehouseman 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura Givens L.D. Arnold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14108 Manor Rd., Phoenix, Md 21131 Lola Sue Kayler (daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial 2-25-04 Marriottsville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Parge Haight 2 expert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** S. uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown been signed by to should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ac autopsy performed page Serus 1 ☐ Yes 2 TNo certificate 1 Yes 2 🗹 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending after death.

Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a To the Funeral C 🗷 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bungho old 32. Registrar's Signature 31. Date filed (Month, State 4 Registrar

				For State Registrar	tate of Maryl	and / Depa	artment c	of Health a of Death	nd Mental H	ygiene Reg. No. 2	004	05685
				Decedent's Name (First, Middle, Last)					2. Date of D	eath Day	Year	3. Time of Death
3,		Physici /Medic		Helen c. Adkins					02	22	2004	9:40 P ^M
1		Examin	_	la. Facility Name (If not institution, give stree				wn, or Location of	Death		nty of Death	_
£				Pickersgill Retire 5. Social Security Number 6. Sex		yrs. last birthday)	TOW If Under 1 Y		4 Hrs. 8 Date of F		1timor	ace (State or Foreign
ADVINS, HE		Funeral Director		214-40-2840		88 Yrs.		ays Hours	Min. (Month, 1 11/1	Sirth Day, Year) 5/1915	Mary	ry)
7.		and		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				10	d. Inside City Limits
\mathcal{F}		ith with the Marylan 23a or 28e-f show	ctor	MD Baltimore	e	Towson	1.5.5.			40- Citi	at Mhah Caust	1 □Yes 2 No
2		3a or 2	I Dire	10e. Street and Number 615 Chestnut Ave			10f. Zip Co	21204	1	U.S	of What Count	ry r
2		death	ner	11. Marital Status 12.	Was Decedent Ever	in U.S. 13.	Was Decedent	t of Hispanic Orig	in? (Specify Yes or I Puerto Rican, etc.)	lo- 14. F	Race - America Black, White, e	
140	920	filed within 72 hours after death with the Maryland Hygiene. other than "naturel", or Hems 23a or 28e-f show ent, the Macical Examiner must be notified at	Completed by Funeral Director	1 Never Married 2 Married	1 □Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 X		,		^{cify:} whi	
11	5-0	72 hc "natur	etec	15. Decedent's Education (Specify only highest grade co	on Impleted)	16a. Deced	dent's Usual O	occupation done during most retired)	of working	16b. Kind o	f Business/Ind	ustry
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40/	Marýland 2	e d a b	To Be C	17. Father's Name (First, Middle, Last) William Ayres					's Name <i>(First, Midd</i> na Schmidt	le, Maiden Sun	name)	
12	Marý	d 2 should th and Men 7 Is marke treumatic	() ta	19a. Informant's Name/Relationship (Type, Margaret Adkins, C				treet and Number	o <i>r Rural Route Nurr</i> Santa Fe		wn, State, Zip 37594	Code)
4		of Health of Health litem 27 r other tr		20a. Method of Disposition	20	b. Place of Dispo cemetery, crer			Date 02/25/2004	-	on - City or Tox	wn, State
	Baltimore,	Page tment o tant: If jury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Remo 1 ☐ Donation 5 ☐ Other (Specify)		Hilltop		e Corpor	ration	Towso		
	Ball	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Licensee	hristina H Vello	lilton 22	Signal A Sig	arford F	Leonard J Road Balt	Ruck,	MD 212	14
	760,	Physician /Medical Examiner physician and physician and physician and physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are ph	licai Examiner	shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d		nsequence of):	min					Onset and Death
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	۵	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical Ce	29a. Certifier (Check only one) Certifying Physici.	an: To the best of my : On the basis of exa and manner stated.	knowledge, deat mination and/or in	h occurred at t vestigation, in	the time, date and my opinion, deat	d place, and due to the hoccurred at the time	e cause(s) and e, date and pla	manner as sto ce, and due to	ated. the cause(s)
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		5		30. Name and address of person who comp	pleted cause of death	(Kerry23a) (Type,	Print) Cha	les St	holto.	md =	2120	٤
		Sta Regist		31. Date filed (Month, Day, Year) FEB 2 4 2004	32. Registrar's S	Signature	who .					

		For State of Man			of Health and Ne of Death		ene 2004	05686
Dhusisia	3	Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
Physicia /Medica			V. Bu	schman		Februar	y 22 2004	3:15 PM
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	- 2	Tranklin Square (105D) Tall 5. Social Security Number (6. Sex 7. Age (1)	In yrs. last birth	hday) If Under	Kosedal 1 Year If Under 24 Hrs.	O Date of Dish	Ball	imore
Funeral Director		214-40-6562 ** 2 = F		rs. Months	Days Hours Min.	8. Date of Birth (Month Day, Y Jan4, 19	(ear) 9. Birthpi	ace (State or Foreign try)
		Usuel Residence of Decedent				bully	MAT	yland
ms 23a or 28a-f show		10a. State 10b. County 10	0c. City, Town	or Location			10	Od. Inside City Limits
or 28a-f show	cto	MD Baltimore		1	Essex			1 ☐ Yes 2√2 No
or 26	Oire	10e. Street and Number		10f. Zip		10g	. Citizen of What Count	ry?
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Exand actional be rutilled at	by Funeral Director	11. Marital Status 12. Was Decedent Eve Armed Forces?	ir in U.S.	13. Was Decede	ent of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
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natural, or items idical Examination	ed	15. Decedent's Education	16a	Decedent's Usual	Occupation	161	b. Kind of Business/Ind	u ata c
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other treumatic event, the Medical		19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address	Street and Number or Rura	al Route Number, C	ity or Town, State, Zip (Code)
other tr		JohnBuschman/brother	3	21 Mont	crose Ave.	Baltimo	re MD	
or off		20a. Method of Disposition 1	20b. Place of I cemetery	Disposition (Nam. r, crematory or oth HillCer	e of [ner place)		c. Location - City or Tow	
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any in		21. Signature of Funeral Service Licensee	11	22. Name and	Address of Facility Co	onnellvF	uneralHon	neofEccos
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Æ	NCE BROOK	S	For State Registrar	State of Maryland	Depa Cei	artment rtificate	of H	ealth a Death	ind Me	ental Hy	giene 2	004	05688
	Physici /Medic		1. Decedent's Name (First, Middle, Las	Richard	R	rook	<			2. Date of De Month FEB		Yeer	3. Time of Death 12:26 PM
2	Examin		4a. Fecility Name (If not institution, give 3127 MARECO AVENUE			4b. City, To	own, or	Location o				unty of Death	
1	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 1 2 8 - 48 - 4996 1 Usual Residence of Decedent	7. Age (In yrs. last	birthday) Yrs.		Year Days	If Under 2 Hours	Min.	8 - 7	rth ay, Yeer) - 194		place (State or Foreign intry)
	the Maryland r 28a-f show	Director	10a. State 10b. County Maryland 10e. Street and Number	10c. City, To		cation	code				10g. Citizen	of What Cou	10d. Inside City Limits 1 Yes 2 No
036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show in Mudical Ezam ar must be neitiled at	by Funerai	4245 Shamro 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 Dives 2 No If Yes, Give Year or Dates:	1		/		in? (Spec Puerto Ri	fy Yes or No	0- 14.	SA Race - Ameri Black, White, ecity: Blo	etc.
Maryland 21215-0036		Be Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12 Upg 15 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done du retired)	uring most					tation
Maryla	nd 2 should be filed lith and Mental Hyg 27 Is marked other r traumatic event.	Tol	David Brooks 19a. Informant's Name/Relationship (7 Laney Brooks /					nd Number	or Rural I		er, City or To		Code) 40 21206
Baltimore,	es 1 an of Heal filtern 2 r other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Other (Specify	Removal from State 20b. Place ceme	of Dispo tery, crer	sition (Name natory or oth	of er place	,	Da	te	20c. Locati	on - City or To	
Balt	permit. Pag Department Important: I any injury o once.		21 Signature of Funeral Service Licen		Ho	. Name and	Address	of Facility	Home	e HI		berty	Heights
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) 5. Cuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or as a consequence) Due to (or as a consequence)	ent	er the mode	ot dying.	, such as c	ardiac or i	Pespiratory a	rest,		Approximate Interval Between Onset and Death
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Vital Record	en: The law tificate has b tor, page 2 st	Be Completed	25. Was case referred to medical					OS Place	of Dogsth //	24a. Was autor perfo 1 Yes	osy ormed? 2D No	prior to cou death?	psy findings available mpletion of cause of
Division of Vi	I or Attending Physicien: The after death. Director: After this certificate ha fin by the funeral director, page	Certification; To B	examiner? 1 \times Yes 2 \to No 27. Manner of Death 1 \times datural 5 \to Pending investigation 3 \to Suicide 6 \to Could not be determined	Hospital: 1 Inpatient 2 ER/C 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify)	. Time of Injury	M 280	Other Injury a Work?	4 🗆 Nurs	sing Home 286	5 🗌 Resid	dence 6XX	curred	AT SCENE
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one) 1□ Certifying Phy 2☆ Medical Exem	sician: To the best of my knowled iner: On the basis of examination a and manner stated.	ge, death and/or inv	occurred at estigation, in	the time my opir	, date and nion, death	place, and	d due to the at the time.	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)
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	")		30. Name and address of person who could be seen and address of person who could be seen and address of person who could be seen address of person address of person who could be seen address of person address o	ompleted cause of death (Item 23a 111 32. Registrates Signature			, Bal	timore	e, Mary	yland 2	1201		
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			For State Registrar	State of Maryland / Dep Ce	partment of Health and I pertificate of Death	Mental Hygiei	
	Dhusisi		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death Day Year
	Physici /Medio		MAURICE	S	BUSCH	FEBRUARY	
	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	1	4c. County of Death
			GENESIS ELDERCARE 5. Social Security Number 6. Sex		ANNAPOLIS If Under 1 Year If Under 24 Hrs.	8. Date of Birth	ANNE ARUNDEL 9. Birthplace (State or Foreign
ŀ	Funeral Director			M 2□F 78 Yrs.	Months Days Hours Min.	8/5/1925	BECKLEY, WV
	laryland show	J.	10a. State 10b. County	10c. City, Town or I			10d. Inside City Limits 1 ☐ Yes ②∰No
	28a-f	ect	MD ANNE A	ARUNDEL GLEN	BURNIE 10f. Zip Code	109.	Citizen of What Country?
	3a or	0	7970 NOLCREST RO	OAD	21061		USA
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Items 23 or 28a-f show if Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avant, the Medical Examinant be rectified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married **XWidowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 XIXes 2 No If Yes, Give Year or Dates: WWII	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes XXX No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
Q 2	72 ho	ed	15. Decedent's Edu (Specify only highest grade	e completed) (Giv	edent's Usual Occupation re kind of work done during most of wor		. Kind of Business/Industry
7	within iene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired) CRUCK DRIVER		TEAMSTERS
	filed w Hygier Ather th		17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid	
anc	ould be fi Mental H arked ot atic svs	Be.	FELIX BUSCH			DAPAUS	ion demandy
Maryland	2 should and Men Is marke aumatic	၉	19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Mai	iling Address (Street and Number or Ru	ıral Route Number, Ci	ty or Town, State, Zip Code)
	1 and 2. Health a tem 27 is		RACHEL J. BUSCH	- DAUGHTER 7970	NOLCREST ROAD, G	LEN BURNIE	, MD 21061
Baltimore,	permit. Pages 1 and Department of Heall Important: If Item 2 any injury or other page.		20a. Method of Disposition	20b. Place of Disposer Competery, cr	position (Name of ematory or other place)	Date 200	. Location - City or Town, State
<u>E</u>	Page ant: M		1 XXurial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	MARYLANI	VET CEM 2/20	/2004 C	ROWNSVILLE, MD
at	permit. Departr Importa		21. Signature of Fune de Coc Licens		22. Name and Address of Facility F	INK FUNERA	L HOME, PA
_	X0 E 3 3		KELLY GREGORY	FUNK #MO1148	426 CRAIN HIGHWAY	S., GLEN	BURNIE, MD 21061 Approximate
	Physician /Medical Examiner		shock, brheart abure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	Heart fail	LLLL	Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (okas a consequence of): Due to (or as a consequence of):			
.O. Box 68	the death certifi y the attending ched for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B □Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
0	res that igned by be deta	by Pr	Part II. Dther significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Records,	The law requires te has been sign page 2 should be		theunier	A 0		1 🗌 Yes	2 No 3 Probably 4 Unknown
000	aw requir	Completed	Reenal 1	Well		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
		E O		(1		performed 1 ☐ Yes 🛣	I? death?
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case relerred to medical examiner?	la a vani		ath (Check only one)	
of \	d is	2	T Tes ZIXINO	lospital: 1 Inpatient 2 ER/Outpati			6 ☐Other (Specify)
Su C		ion	27. Manner of Death XXNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how i	njury occurred
Division	deat ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, larm, building, etc. (Specify)		28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospital or A within 24 hours after To the Funeral Direction places on places of the filled in by	edical C	29a. Certifier (Check only one) Medical Exami	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred.	e, and due to the cause arred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	ro the within 2	Mec	29b. Signature appretitle of certifier		29c. License number	29d.	Pate signed (Month, Day, Year)
	~X\		• ()		D57028	2/	23/04
	18		30. Name and address of person who can also be a second of the second of	ompleted cause of death (Item 23a) (Typ	o. Frint) 1 AUT. Ste. 231 AN	MADNIT	S.MD 21401
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1000	VIVIE	
	Regist		0 4 2004	Proces M. Appen			
DH		2001	FEB 2 4 2004	1		, , , , ,	

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State of Maryland / Department of Health and Mental Hygiene 2004 05690 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Ella Pearl Beach February 23, 2004 7:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5804 Oakland Road Halethorpe Baltimore If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🖫 F Yrs. Director 84 212-18-5940 Jul. 8, 1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No Director Baltimore Halethorpe 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō or items 23a 5804 Oakland Road death 21227 Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2√ No Specify: à 3X Widowed 4 □ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Own Home peli marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be t Department of Health end Mental I Important: If Itam 27 is marked o Frank Shell Ella Theresa Scholz ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Davis Daughter 5804 Oakland Rd., Halethorpe, MD 21227 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Bayview Crematory, Inc. 2-24-2004 Baltimore, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Ambrose Funeral Home, Inc. Puy 1328 SUlphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician /Medical resulting in death) Due to (or as a consequence of): andenna Examiner H AS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and Due to (or as a consequence of) attending physicien a for use as the burial-Physician/Medical use as IE EEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year signed by the a 5 Other (specify) P.O. I Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page certificate 1 Yes 2 No 1 Tyes Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 2 1 Yes 2 ANO 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. De cribe how injury occurred Medical Certification: After or Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: / completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 005050 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 9 140 Seaverbrook 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 4 2004 Registrar

		1	For State Registrar	State of Maryland	/ Department of Health and Certificate of Death	Mental Hygien	
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	pu *	- F	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location		10d. Inside City Limits
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	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Mudical Examiner must be nutilised at	Director	10e. Street and Number		10f. Zip Code	10 g . 0	Citizen of What Country?
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	er der Itams Dier m	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces?1 Yes 2 No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, etc.
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on	After funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	250. 55001.50 1.011	13.7 3333.733
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3		30. Name and address of person v	P. Jonz		_	Print) 695	1	me	rich	121	035		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 05693 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 9:45 P Bohager Wilhelmina February 20, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Towson Balt<u>imore</u> n 1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Maryland Yrs Director 218-18-0238 80 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural, or Items 23s or 28s-f shov 1 ☐ Yes 2X No Director Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 8255 Poplar Mill Road 21236 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Ites ury or other traumatic event, the Madical Examinal Black White etc. 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Andrew Hiebler Elizabeth Miller 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Bohager/son 8255 Poplar Mill Road Nottingham, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 02/24/2004 4 ☐ Donation 5 ☐ Other (Specify) Overlea, Maryland 22. Name and Address of Facility 21. Signa re of Funeral Service Ligensee Ruck Towson Funeral Home, Inc. S. Coster 1050 York Road Towson, maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** DEHYDRATION 100001 resulting in death) /Medical Due to (or as a consequence of) Examiner PARKINSUNIS 015110517 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day signed by the aid be detached for 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗆 Yes 3 Probably 4 Unknown Should peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 autopsy certificate 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Division of Vital Records, P.O. Box 68760,

or Attending Physician: After this lilled in by the funeral death. s after death To the Hospital 24 hours a Vithin 2

State Registrar

Medical

31. Date filed (Month, Day, Year)

3 C Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifie

6 Could not be

determined



Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Dav. Year)

FFB VANY 21 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1)27838

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 State AMEND ITEM #1 PER PHY G829 3/15/04 JEC ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200 DOESRY DORSEY BROCKINGTON BROCKINGTON /Medical 4a. Sacilly Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of De Examiner amaijoa 2000 lo mov If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1**X** M 2 □ F 62 Director 244-62-4762 NC OCT. 21 1941 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No NA BALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 633 Funerai STREET 4JUSA 21202 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married AFRICAN 1 ☐ Yes 2 No þ Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates AMERICAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 SALESMAN SHOE COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNK Be ESSIE KEMP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY P. BROCKINGTON (WIFE) 1829 E. CHASE STREET BALTIMORE, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ZION CEMETERY 2/26/04 LANSDOWNE, MD 22. Name and Address of Facility WYLIE FUNERAL HOME PA 21. Signature of Funeral Service Licenses 638 N. GILMOR STREET BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition U 70 Ca resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 Ne 1☐Yes 2☐No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one: Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 1 Inpatient 2 X ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician /Medical Examiner the attending physicien and the for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by peen has this certificate or Attending Physician: After death. within 24 hours efter death To the Funeral Director: in by t

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Baltimore, Maryland 21215-0036

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permit. Peges 1 end 2 st Department of Health and Important: If item 27 ie m eny injury or other traum

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State Registrar

Medical

31. Date filed (Month, Day, Year)

29h. Signature and title of certifier

29a. Certifier

pleted cause of death (Item 23a),(Type, Print) Laven Loch

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

32. Registrar's Signature Darks 2004 4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05695 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Yea MARY BAKER 7-15PM FEB 194 2004 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea June 28, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdev) Birthplace (State or Foreign Country) **Funeral** Year) Months 1 ☐ M 2X F Days Hours 212-34-1964 1936 Maryland Director Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 XYes 2 □ No Director N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours efter death with Depertment of Heelib and Mertel Hygiene. Important: If item 27 is marked other than "natural; or items 23s or any injury or other traumatic event, the Medical Examiner must be a say injury or other traumatic event, the Medical Examiner must be a 3323 Kenyon Avenue 21213 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2XXNo If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 200 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry na most of working Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Caroll E. Wright Helen Hartung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3323 Kenyon Avenue Baltimore, Maryland 21213 John Baker Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1

Burial 2 □ Cremation 3 □ Removal from State 2/23/04 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill 21.\Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical IS CHEMIC HEARY DISTAGE NONTHS Examiner Due to (or es a consequence of): Physician/Medical Examiner APIRATION PNEUMONIA Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Division of Vital Records, P.O. Box 68760, MONTHS ACCIDENT CERT BROVASWIAN Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Medicai Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? ours efter deeth.

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sharfe WD P0053150 FEB 200 2004 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

Registrar

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32. Registrar's Signature

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31. Dete filed (Month, Day, Year)

FEB 2 4 2004

7700 YORN RD TOWSON MOZNOY

State of Maryland / Department of Health and Mental Hygiene 2004 05

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DHMH 16 Rev 6/95

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Registrar

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Funer Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, Ite Medical Expertment within the collided at Baltimore, Maryland 21215-0036

Patient Known As: Dokothy CROSBY

Physicia /Medic Examin

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

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	Immediate Cause (disease or condition resulting in death)	(rinai n	a5	epsi	Son seguence	a of):							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Crosby

Dorothy

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2004

2. Date of Death

Month

Day

February 19,2004

05698

3. Time of Death

10:16 A-M

Reg DHMH 17 Rev

DHMH 17 Rev 1/2001

RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 2 2

			For State Registrar	State of Maryla	Cer	tificate of De	ath	Reg.		. 00000
•	Physicia		Decedent's Name (First, Middle, La:	- 1 1	76				Day Year	3. Time of Death
1	/Medic	al -	Kenneth 4a. Facility Name (If not institution, giv.	Campbel a street and number)	1	4b. City, Town, or Loc		EBRUARY	12, 2004 4c. County of Dea	3:45P.
	Examin	-1	MARYLAND GENERAL I			BALTIMORE			N	/A
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In y	rs. last birthday)	If Under 1 Year If U		Date of Birth	9. Bir	thplace (State or Foreign buntry)
	Director		219-74-1618	□M 2□F 4	Yrs.	Months Days He	Dura William	Date of Birth (Month, Day, Ye larch 30,	1959	MD
	pur *	-	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	cation				10d. Inside City Limits
	Aaryla r sho	5			Balt					1 les 2 No
	28a-	Director	N/A 10e. Street and Number		J-0/1	10f. Zip Code		10g.	Citizen of What Co	ountry?
	h with	a D	3436 Auch. Te	race		11215	7		US	A
	deat dems 2	Funeral	11. Marital Status	12. Was Decedent Ever in	n U.S. 13. V	Vas Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Specif lexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, Whit	
36	or its		1 Never Married 2 Married	1 ☐ Yes 2 ☑ No			pecify:		Specify: R	lack
21215-0036	72 hours after death with the Maryland natural; or items 23s or 28s-f show lical Examination relations	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16a, Deced	ent's Usual Occupation	1	16b	. Kind of Business	
15	n "na	Completed	(Specify only highest gra Elementary/Secondary (0-12)		(Give	kind of work done durin OO NOT use retired)	g most of working			, 1
212	filed within Thygiene. Hygiene other then "rent, in a Me	E O	10±1			Laborer				twoky
p	be filed tal Hygi d other event, t	Be	17. Father's Name (First, Middle, Last			18.	Mother's Name (f			
Maryland	should be nd Mental marked c	ပ	19a. Informant's Name/Relationship	me bell	10h Mallin	g Address (Street and I			in or Town State	
Mar	12 sh h and 7 is n traun		Tamme Campb		22				oul, Mes	
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiens the Marylan tiem 27 is marked other then "natural", or items 23a or 28a-f show tiem 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, I a Medical Examinating transitive rigilities at		20a. Method of Disposition		b. Place of Dispo	sition (Name of	Dat		Location - City or	
Baltimore,	0 0		1 Burial 2 Toremation 3 C 4 Donation 5 Other (Special	Removal from State	cometery, cren	natory or other place)	2/21/	σψ	3 House	e. Mr
ij	permit. Page: Department o Important: If any injury or		21. Signature of uner Service Lice	nsee	22	. Name and Address of	Eacility 1359	Funera	I S Enve	e, MD te, P.A. o 21201-1925
ä	Deparenti Importany ir		1 1			1709	Tessie	S1. B	alt. M	0 21201-1925
1			23a. Part1. Enter the disease, or com shock, or heart failure. List only	aplications that caused the d	death. Do not ente	er the mode of dying, su	uch as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
2	Physician		Immediate Cause (Final disease or condition	a LIVER C	IRPHOSI.	S WITH	COMPL	CATION	2.	Chiser and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):					
4	4 ***	je.	Sequentially list conditions,	b. Due to (or as a con	sequence of):					
	uted 1 Insit	mln	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
ć	exection and and rial-tra	Exa	resulting in death) Last	Due to (or as a con	sequence of):			_		
68760,	icate be executed physician and s the burial-transit	edical Examiner		d						
	≘ ტო		IF FEMALE:							
Вох	n requires that the death certifi been signed by the attending should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	or death 3	Other (specify)				
P.O.	requires that the een signed by th nould be detache	y Ph	Part II. Other significant conditions	contributing to death but not	t resulting in the u	nderlying cause given in	Part I.	23e. Did tobac	co use contribute t	o the cause of death?
rds	quires n sigr ald be							1 ☐ Yes	2 🗆 No 3 🗆 P	robably 4 RUnknown
Records,	aw rec s bee 2 shor	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	The law te has bage 2:	E						performed	d? death?	
ita	ysician: The list certificate hadirector, page	Be C	25. Was case referred to medical examiner?	1			i. Place of Death	Check only one		
of Vital	Physician: this certific ral director,	2	1 Yes 2 □ No		2 ER/Outpatier				e 6 Other (Spe	ecify)
'n	fer fer fer fer fer fer fer fer fer fer	Certification:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Work?	2 \(\text{No} \)	d. Describe how	injury occurred	
Division	death death ctor: A	icat	2 Accident investigation 3 Suicide 6 Could not	be Ose Bless of lainer	At home, farm, str					Tural Route Number,
Ď	after Direct	ertif	4 Homicide determined	building, etc. (Sp	pecify)			City or Town, S	State)	
	spita hours ineral	a C	29a. Certifier 1□ Certifying P	Physician: To the best of my	knowledge, deatl	occurred at the time, o	date and place, an	d due to the caus	se(s) and manner a	s stated.
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check only 2X Medical Exa	aminer: On the basis of examiner and manner stated.	mination and/or in					
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier			29c. License nu	ımber	29d.	Date signed (Mon	in, Day, Year)
	N		, met				.M.E.	FEB	RUARY 13	,2004
	8		30. Name and address of person who	SIO, HD	(Item 23a) (Type,		the st	~7 ± 2	. W 7	-4 21201
	C+	ate	31. Date filed (Month, Day, Year)	32 Registrar's S	Signature	111 Penn S	treet, B	attimore	, maryla	DO 21201
1	Regist		FFB 2 4 20			after of				

ORIGINAL

			1 - For State Registrar	State of	f Maryland	l / Depa <i>Cei</i>	artment of H rtificate of L	ealth ar D <i>eath</i>	nd Mental Hy	giene 2	004	0570
	Physici		1. Decedent's Name (First, Middle, Last Evelyn Marie		ta				2. Date of Di Month	eath Day	Year 2004	3. Time of Death 8:36 A M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of [4c. Count		
ı	Exami	ei	4 Acorn Circle, a				· _	son			altin	
	Funeral Director		5. Social Security Number 6. Se		7. Age (In yrs. las	st birthday) Yrs.	if Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi (Month, D Aug. 2	rth	9. Birth	plece (State or Foreign ntry) Wyland
			Usual Residence of Decedent						71009 • 2	-,		o cy-certa
	nylan nhow		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Ba-f a	cto	Maryland Balti	more			Towson					1 □ Yes 2 No
	vith th	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of		•
	a 23s	eral	4 Acorn Circle, Ap		dent Ever in U.S.	10.1		286	2/0		S. A	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinations to notified.	y Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🛣 Divorced	Armed For 1 ☐ Yes If Yes, Giv	rces? 2 X No e	i	was Decedent of Hi f Yes, specify Cubai 1 ☐ Yes 2🛱 No	spanic Origin n, Mexican, F Specify:	n? (Specify Yes or N Puerto Rican, etc.)	Bla Specif	ck, White,	can Indian, etc. ute
21215-0036	hour	Completed by	15. Decedent's Edu	Year or Da		16a, Dece	dent's Usual Occupa	tion		16b. Kind of B		
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2	filed with Hygiene other the	Com	12th Grade	College (1	401 34)		Homemake	r		Owi	n Hom	ie.
g	al Hygie d other	Be (17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle		πe)	
Maryland	Mental Mental Marked o	To	Vincent S. Hennes						Mary E.			
ā	12 sh n and n m n m reum		19a. Informant's Name/Relationship (T)						or Rural Route Numb			
	1 and Health em 27 ther t		Lawrence J. Hennes 20a. Method of Disposition	sey (b)					Date Date	20c. Location		
nor	Pages nent of int: If its iry or o		1 🕅 Burial 2 ☐ Cremation 3 ☐ F		Jiaia		sition (Name of natory or other place				•	
Baltimore,	permit. Page Department. Important: It any injury of		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 		MOSA		Redeeme	L Z/:	24/2004 Schimunek	Baltumo	re, 1	Maryland
ä	Depar Import any ir		1/2	5					senumuner ., Baltimo			
			23a Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that ca	aused the death.						jeunu	Approximate Interval Between
	Physician	-	Immediate Cause (Final disease or condition				NG CAN	~				Onset and Death
	/Médical		resulting in death)		or as a conseque		IV G CAVI					3 MONTHS
	Examiner		Sequentially list conditions,									
۲	p H	Examiner	cause. Enter Underlying	utia to (Dua to (or as a consequence of).							
	ecute and trans	kam	Cause (Disease or injury that initiated events resulting in death) Last	Due to (25.25.2.2222222	unaa ati):					_	
8760,	cate be executed physicien and the burial-transit	al E		Due to (i	or as a conseque	ince oi).						
587	icate phys s the	dical		d								
Box (death certifi e attending id for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnanc					23d Da	te of delive	arv
.O.	it the death certific by the attending parched for use as	Physiclan/M	In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 □ Fetal d ant at time of dea wn		Ectopic pregnancy Other (specify)				nth	Day Year
a	that the ed by detac	Ph	Part II. Other significant conditions co	ntributing to de	ath but not result	ing in the u	nderlying cause give	n in Part I.	23e. Did	tobacco use cont	ribute to ti	he cause of death?
ords,	w requires tha been signed should be del	ted by								Yes 2 □ No		
Records,	e la has	Completed					1.0		24a. Was auto perfe	psy prmed?	Were auto prior to co death?	psy findings available mpletion of cause of
Vital			25. Was case referred to medical					26 Place of	1 ☐ Yes Death (Check only	7.4	1 🗆 Yes	2 No
5	di s	o Be	examiner?	lospital:	npatient 2 EF	P/Outpatien	t 3 DOA Othe	r	ng Home 5 Z nesi		er (Specif	(v)
on of		Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date o		8b. Time of Injury	Work	at	-	how injury occur		,
Division	or Attencater death Director:	fica	3 Suicide 6 Could not be	28e. Place	of Injury - At hom	e, farm, str		03 Z	28f. Location (Street and Numb	er or Rura	al Route Number,
á	al or safter	Serti	4 Homicide	buildin	ig, etc. (Specify)	-			City or To	wn, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the ner; On the ba and mann	isis of examinatio	edge, death n and/or inv	occurred at the time restigation, in my op	e, date and p inion, death o	place, and due to the	cause(s) and ma date and place,	inner as s and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier)			29c. License	number		29d. Date signe	d (Month,	Dey, Year)
			> YH TW	MD			Da	9301		2-23	504	
	18		30. Name and address of person who co	-	of death (Item 2	.3a) (Type,						
	\		KATE THU MD	7	3501 108K	62	SUITE 101	A	TOWSOW, M	ID 212	201	
S.	Sta Registr		31. Date filed (Month, Day, Year)		egistro's Signatur	re .	Anasti)		,			
	negisti	21	FEB 2 4	ZUU4	A Brade de	150	Donasti I					

			For State Registrar	State of Mar	yland /	Depa <i>Cer</i>	rtment of H tificate of L	ealth and M Death	lental Hyg	iene 200	4 05701
	Dhysisi		1. Decedent's Name (First, Middle, Las	•					2. Date of Deat Month	Dav Year	3. Time of Death
	Physici: /Medic		EDWARD W. CZA	RNIECKI					FEB. 17	7, 2004	4:55 P ^M
,	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, or			4c. County of Dea	
			GENESIS ELDERCAL 5. Social Security Number 6. S		'In yrs. last bi	irthday	JUN.	DALK If Under 24 Hrs.	8 Date of Birth	BALTIM	
н	Funeral Director			XM 2□F 86	iii yi s. iast bi	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, JULY 20	Year) C.	thplace (State or Foreign ountry)
			Usual Residence of Decedent	100					JULI 20	, 1)11	IA.
	rylan	L	10a. State 10b. County		0c. City, Tov						10d. Inside City Limits
	Ba-f s	Director	MD. N/A]	BALT	IMORE				1)∑Yes 2 No
	or 2	Dire	10e. Street and Number	DEET			10f. Zip Code	21224	11	Og. Citizen of What Co U.S.A.	ountry?
	s 23s	eral	632 S. OLDHAM ST	12. Was Decedent Ev	or in II S	112 1	Vac Decedent of Hi		poifu Vae at No-	14. Race - Am	erican Indian
036	72 hours after death with the Maryland Inatural, or Items 23s or 28s-f show deal Exacilist must be incitified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:	91 III O.S.		Vas Decedent of His Yes, specify Cubar	Specify:	Rican, etc.)	Black, Whi	
2-003	72 hours "natural", dical Ex	eted	15. Decedent's Ed (Specify only highest gra		16a	(Give	ent's Usual Occupa	urina most of worki	ng	16b. Kind of Business	/Industry
21	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. t	OO NOT use retired)			ODOLBI GO	DIX 0 CD41
22	filed v I Hygie other t	S	17. Father's Name (First, Middle, Last)			LADU	KEK	18. Mother's Name	(First Middle N	CROWN, CO	KK & SEAL
Maryland	ed la b	To Be	WALTER CZARNIECK						NE UNKNO		
7	d 2 should be h and Menta 7 Is marked traumatic ev	ř	19a. Informant's Name/Relationship (Type, Print) GRAND	19	b. Mailin	g Address (Street a			City or Town, State,	Zip Code)
	nd 2 alth a 27 Is		CHARLOTTE ELIOPO		ΓER	1110	4 GLEN A	RM ROAD,	GLEN ARM	1, MARYLAN	D 21057
Baltimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		cemete	ary, cren AWN	sition (Name of patory or other place CEMETERY	" 2/20	/04 F	POC. Location - City or BALTIMORE,	MARYLAND
Balt	permit. Pag Department Important: I any injury o		21. Signature of Fune al Service Licen	see	-					ZEILER & DRE, MARYL	
			23a. Part1. Enter the disease, or com shock, or hear failure. List only	plications that caused the	e death. Do	not ente	er the mode of dying	, such as cardiac o	r respiratory arre	est,	Approximate Interval Between
	Pnysician /Medical		Immediate Cass (Final disease or condition resulting in death)	a. Due to (or as a	ARI consequence	51 A	LIN	FARC	TION		S Onser and Depth N
	Examiner		Sequentially list conditions.	PORONI	1RY	/	+R110	RY DI	SEA	ZE	9 YEARS
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence	of):	H JA	YPEP	TENO	14012	164FARS
	al-trar	Exan	that initiated events resulting in death) Last	C. Due to (or as a c	consequence	of):	" " " " " " " " " " " " " " " " " " " "	DISLACA	10016	21014	10/11/10
98760	icate be executed physician and s the burial-transit	edicai I		HRONIC	OBST	RV	TIVE	PULMIUI	unky	DISEASO	E ISYEAR
_			IF FEMALE:						`		
O. Box	at the death certifi by the attending tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 ∫ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetel death		Ectopic pregnancy Other (specify)		92 2	23d. Date of de Month	livery Day Year
ds, P	ss this	þ	Part II. Other significant conditions of	ontributing to death but i	not resulting	in the ur	derlying cause give	n in Part I.		acco use contribute to s 2 □ No 3 Pr	the cause of death?
Records,	e law require has been sig ge 2 should b	Completed					•		24a. Was ar autopsy	prior to	utopsy findings available completion of cause of
E E		Con							perform 1 ☐ Yes 2	ned? death? No 1 ☐ Yes	2 □ No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of Death			
ō	Phys r this ral di	1: 70	1 ☐ Yes 2 Î No 27. Manne: 1 Death	28a. Date of Injury	28b.	utpatien Time of	28c. Injury Work	4 I Nursing Hor		nce 6 Other (Spe winjury occurred	cify)
0	nding F ith. : After e funer	atior	1	(Month, Day Y	(ear)	Injury		? ′es 2 □ No			
Division of	al or Attendi a after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, f (Specily)	arm, stre	eet, factory, office	2	28f. Location (Str City or Town	eet and Number or Ri , State)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the tuneral director,	Medical (29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of rainer: On the basis of each and manner state	xamination at	e, death nd/or inv	occurred at the tim estigation, in my op	e, date and place, a inion, death occurre	and due to the ca	use(s) and manner as ite and place, and due	s stated. to the cause(s)
	To the To the Comp	W	29b. Signatura and this of certifier	ngh m.	D .		29c. Lipense	number (6	O FE	BRUARY	8, 2004
	Ŋ		3 Janetara addrása orporson gro	ORE of dayse of dear	th (tem 23a)	1500 M	10-A AND -	RITCH 2122	JE H	GHWA	()
1	Sta Registr		31. Date filed (Month, Day, Year) FFR 2, 4, 2004	32. Registrar's	s Signature	Soi	aks!				

			1 - For State Registrar	State of Maryland / De	epartment of Health and Certificate of Death	d Mental Hygien	
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last ONATH 4a. Facility Name (If not institution, give	AN DUKE	4b. City, Town, or Location of De	2. Date of Death Month D	Year 3. Time of Death 4/19AM
	Funeral Director	ier	BON Secour 5. Social Security Number 6. Se	s Hospital	Baltimore tay) If Under 1 Year If Under 24 Hours Months Days Hours M		9. Birthplace (State or Foreign
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland NA	10c. City, Town o	Baltimore	1000007	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 844 W. Fay-e	the St.	10f. Zip Code 2/20/	10g. C	itizen of What Country?
900	72 hours after death with the Maryland natural', or items 23s or 28s-f show acal Examiner must be maillied at	þ	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	d within plene. r then the Mex	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation 16a. Do (G (G)iii	acedent's Usual Occupation live kind of work done during most of v le. DO NOT use retired) Messenge		Kind of Business/Industry and's Messenger Service
Maryland	should be filed nd Mental Hygis marked other matic event, the	To Be (17. Father's Name (First, Middle, Last) John Johnso		Dais	lame (First, Middle, Maide) Y Dukes	
	s 1 and 2 should be filed If Health and Mental Hyg Item 27 Is marked othe other traumatic event,		19a. Informant's Name/Relationship Ty Geraldine Bu 20a. Method of Disposition	iss-friend 84	ailing Address (Street and Number of 4 W. Fayette sposition (Name of	St. Ballin	rore, Maryland
Baltimore	t. Page rtment o rtant: If njury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensu	temoval from State Metro	crematory or other place) 2. Name and Address of Facility 1.	12404 Ca	cocation City or Town, State tonsville Marylan
Ba	Depa Impo impo sny ii		23a. Part 1. Enter the disease, or complete or head failure. List only or	arker :	3512 Frederick	Ave. Baltin	nore Maryland 2122
	Physician and Medical Street Physician and Physician and Street Physician and Street Physician Street Physic	edical Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	EMIA L Endoca nows Drug		Interval Between Onset and Death
P.O. Box 6	- D a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	w requires that to been signed by should be detac	by	Part II Other significant conditions con	tributing to death but not resulting in the	a underlying cause given in Part I.	23e. Did tobacco t	use contribute to the cause of death?
al Records,	certificate has been ector, page 2 should	Completed		SION, ANEX	1/7	24a. Was an autopsy performed? 1 ☐ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of Vital	Shis a	Certification: To Be	27. Manner of eath 1 Statural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28a. Place of Injury 28b. Time Injury 28b. Time	ient 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No	eath (Check only one) Home 5 Residence 28d. Describe how injur	ry occurred
2	within 24 hours after To the Funeral Directory completely filled in by		4 Homicide determined 29a. Certifier 1 Certifying Phys	28e. Place of Injury - At home, farm, building, etc. (Specify) ician: To the best of my knowledge, de	ath accurred at the time, date and place	City or Town, State	
,	within 2-	Medical	29b. Signature and title of certifier	ar: On the basis of examination and/or and manner stated.	29c. License number	curred at the time, date and	te signed (Month, Day, Year)
X	Stat Registra		30. Name and address of person who con FA HAMI Ton, I all a state filed (Month, Day, Year) FFR 2 4 2004	npleted cause of death (Item 23a) (Typ 1) September 23a) (Typ 23a) (Typ 23a) (Typ 23a) (Typ)	e Print) South 2000 V	V. BALTHOR	R, BALTHORE, 21223

	1 - State of Ma	ryland / Department of Health and N Certificate of Death	Mental Hygiene 2004 05703
Physician	1. Decedent's Name (First, Middle, Last)	Danses	2. Date of Death Month Day Year Feb. 21 2004 6:04AM
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 6. Social Security Number 6. Sex 7. Age	4b. City, Town, or Location of Death TOWSON (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	4c. County of Death BALTIMORU 8. Date of Birth 9. Birthplace (State or Foreign
Funeral Director	214-38-7877 11MM 20F	43 Yrs. Months Days Hours Min.	(Month, Day, Year) MARYLAND
death with the Maryland ms 23a or 28a-1 ehow ms 23a or 28a-1 ehow mined at mare the motified at meral Director	10a. State 10b. County	Baltimore	10d. Inside City Limits 1
uth with the Mar 23a or 28a-1 el Let be collifed	100. Street and Number 4308 Southern Av	enue 21206	10g. Citizen of What Country? USA
0036 hours after death v hours, or items 23a at Examiner must	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 M I Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	necify Yes or No-Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White, etc.
21215-00 ed within 72 hou vgjene. ser then "natura ser then "natura tr. tra Medical E	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5	16a. Decedent's Usual Occupation (Give kind of work done during most of won life. DO NOT use retired)	16b. Kind of Business/Industry
be fill doth	17. Father's Name (First, Middle, Last) John Dauses	PRINTER 18. Mother's Nam Maru	e (First, Middle, Malden Sumame)
re, Maryla is 1 and 2 should it A leauth and Monit item 27 is marke other traumatic	19a. Informant's Name/Relationship (Type, Print) Rev Jeff Dauses	P.O.BOX 407, HuntVa	al Route Number, City or Town, State, Zip Code)
Baltimore, permit. Pages 1 a Departition of Hea important: if list end injury or othe any injury or othe gince.	20a. Method of Disposition 1 Burial 2 (Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory of other place)	Date / 20c. Location - City or Town, State 2-22-64 FOREST HIII MD 24 Pd Timen ium m 21093
Ball permit permit import import ones in some	21. Signature of Funeral Service Licensee 223a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List ghly one cause on each lire	THU PEACEFUL ALTERI	JATIVES FUNERAL+CREMATIO
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	a consequence of):	Interval Between Onset and Death
(AC:C4-4M) 8760, ate be executed the burial-tran sit the burial-tran sit directly and the burial-tran sit directly are sit directly as the burial-tran sit and the burial-tran	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events c.	a consequence of): a consequence of):	
Records, P.O. Box 6876(The law requires that the death certificate be ten has been signed by the attending physicic agge 2 should be detached for use as the bucompleted by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death be	ut not resulting in the underlying cause given in Part I. Pathological fractive	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown
Il Records, Il Records, The law requires the page 2 should be completed by			24a. Was an autopsy performed? 1 Yes 2 \(\) \(\) \(\) \(\) Yes 2 \(\) \(\) \(\) \(\)
of Vita of Vita hysician: his certifical il director.	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatie 27. Manner of Death 1 Natural 5 Pending (Month, Da)	ent 2 ER/Outpatient 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 Residence 6 Ther (Specify) 28d. Describe how injury occurred
Division of Division of State Gealing Parties of State Gealing Parties of State Gealing Parties of State Sta	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pface of Injuding, etc.	ury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hospita Hospita 4 hours Funaral ely filled	29a. Certifier (Check only one) 115 Certifying Physician: To the bast of and manner sta	of my knowledge, death occurred at the time, date and place f examination and/or investigation, in my opinion, death occu ated.	
	29b. Signature and title of certifier	29c. License number DD0 51926	29d. Date signed (Month, Day, Year) Z (Z C +
8	30. Name and address of person who completed cause of d	leath (Item 23a) (Type, Print) 6565 N. J. Webs St.)	Bathmeno Mo zizoy
State Registrar	31 Date filed (Month, Day, Peak, 4 2004 32. Reciefy	ar's Siggature	

State of Maryland / Department of Health and Mental Hygiene 2004 05704 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Dandridge Jr. 14 6:05 AM 2004 Samuel February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAITIMOVE SINAI 1-105PITA1 BAITIMORE If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Days Hours Director 219-22-8445 74 24 30 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be nutified at 14 Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3702 Columbus Drive 21215 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∆∫Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural; or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes No Specity: Specify: 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Driver M.T.A. na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ James S. Dandridge Sr. Eleanor L. Smith 19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Dandridge Roberts
20a. Method of Disposition 201 5316 Wabash Ave, Baltimore Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State rtment of Magurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) = 5 Department important: If any injury or once. MD National Park 2/24/04 Laurel, Md permit. 21. Signature of Funeral Service March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** PANCreATIC Cuncen METASTATIC resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical use as I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Voar Day 4 Pregnant at time of death signed by the a 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No autopsy 1 Yes 2 No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🛣 No 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1. Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation М 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide I in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) Res 000 February 19 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 hurley 32. Registrar Signature 31. Date filed (Month, Day, Year) State FEB 2 4 2004 Registrar

OANDridge

State of Maryland / Department of Health and Mental Hygiene State State Registrar AMEND TIFM #20b PER FH G828 2/24/04 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1h 18 2004 Month **Physician** FEBRUARY ETTA 21 VAC /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Balto Northwest Hospital Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) 9-26-1915 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 3 € F 164-12-9591 88 Vα Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits or 28e-f show d other than "natural", or Items 23a or 28e-1 show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Balto Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7213 Chalkstone Drive 21208 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black þ Specify: Specify: 3 Widowed 4 Divorced ear or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) 12th grade College (1-4or 5+) if Health and Mental Hygiene. Masters Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Blackwell Gertrude Taylor 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Oliphant - Niece 153 Modena Road Coatesville, Pa 19320 20a. Method of Disposition

1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete permit. Pages Department of H Important: If ite any injury or ot once. 26/04 Garrison Forest Vet Owings Mills, Md 4 □ Donation 5 □ Other (Specify) 21. Signature o Funeral Service Licensee 22. Name and Address of Facility March F/H West Wabash Avenue Balto, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STENOSIS SEVERE BORTIC /Medical Due to (or as a consequence of): Examiner SECONDARY TO HYLLOXIA ENCEPHAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physicien: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical asi the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Dav Year 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown à signed to Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably as been si 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No page 1 Yes rector, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient examiner? 1 Yes 2 No Other: Medical Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA After th funeral 27. Manner of Death (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide filled 1th Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier 29c. License number D0141410 February 18 di JOGINDER P MEHTA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) HUSPITM 21133 WHOALLS TULLY MO CENTER 32. Registrar's Signature State Registrar

ORIGINAL

	1 - For State Registrar	State of Maryland / Dep Ce	artment of Health and I	vientai Hygien Reg. N	2004 0570
Physician	Decedent's Name (First, Middle, Last) Gloria	Holloway	Dunevant	2. Date of Death Month	year 18 2004 4 50 A.M.
/Medical Examiner	4a. Fecility Name (If not institution, give s	HOSPITAL	4b. City, Town, or Location of Deat OLEN DURN If Under 1 Year If Under 24 Hrs	n 4	C. County of Death ANNE ARUNDEL
Funeral Director	497-10-0300	7. Age (In yrs. last birthday 82 Yrs.	Months Days Hours Min.	0ct 8, 192	9. Birthplece (State or Foreign Country) MO
id other than "natural", or Items 23e or 28s-f ahow event, the Medical Exercitor must be notified at Be Completed by Funeral Director	Usual Residence of Decedent	10c. City, Town or L	rnie		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
ittens I Dire	10e. Street and Number 7900 Benesch Circ	le Apt. 780	10f. Zip Code 21060	10g. C	Citizen of What Country?
by Funeral			Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:	specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (Giv.	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking	Kind of Business/Industry
To Be Co	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maide	en Sumame)
2	19a. Informant's Name/Relationship (Ty)	pe, Print) 19b. Mai	ling Address (Street and Number or Ri	ural Route Number, City	
y or other traumatic	Mr. Gary Dunevant 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	20b. Place of Disp cemetery, cre		50 ZI	21212 Location - City or Town, State en Burnie, MD
any injury or other tr once.	21. Signature of Funeral Service License	6	22. Name and Address of Facility S Second Avenue, S	ingleton Fu	neral Home, P.A.
ts the burial-transit and leading the burial-transit and leading the burial edical Examiner	23a. Part1. Sater the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) 5 aquantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	Carcho Misules	0	Approximate Interval Between Onset and Death
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
be o	Patti. Other signmount conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
ral director, page 2 should:	\ <u></u>			24a. Was an autopsy performed 1 Yes 2 2	
I director	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2 ☐ ER/Outpati	Other	ath <i>(Check only one)</i> Home 5☐ Residence	6 ☐Other (Specify)
fune fune		28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how in	njury occurred
completely filled in by the funera	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
To the Funeral Director: completely filled in by the Medical Certifical		sician: To the best of my knowledge, de- ner: On the basis of examination and/or and manner stated.			
	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
S S	1 1 1		アルフィーフ	50	10 anh 11

X		Registrar Decedent's Name (First, Middle, Last	st)	-	Certific			2. Date			3. Time of Death
Physicia		Ida Mary Donov	ran					Feb		ay Year 3, 2004	5:40 a.M
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. (City, Town, or	Location of D			c. County of Death Baltimor	
		Stella Maris F 5. Social Security Number 6. S		e (In yrs. last b	inthoday) If I b	Inder 1 Year	If Under 24 h	Hrs 9 Date	of Righ		
Funeral Director			и жег	88	Yrs. Mon	ths Days		Min. (Mont. Sep	of Birth h, Day, Year t 11	1915 M	place <i>(St</i> ate or Foreigi intry) aryland
> ====	-	Usual Residence of Decedent 10a. State 10b. County		10a City Tou	wn or Location						404 1-24 05 11 5
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Exame act must be multisstated once.	5			Toc. City, Tov	Wit of Location						10d. Inside City Limits 1 ☐ Yes 2₹ No
THE STATE OF	Director	Maryland Baltimo	re	Edgem		. 7:- C-d-			10- 0	itizen of What Cou	
3						f. Zip Code			10g. C	ilizen oi what Cou	iritry :
-	Funeral	3117 Greenhill Ro	ad 12. Was Decedent I	Ever in U.S.		21219	ispanic Origin?	(Specify Yes		Inited St 14. Race - Ameri	
	F.	1 Never Married 2 Married	Armed Forces?					(Specify Yes ouerto Rican, etc.	:.)	Black, White,	
	þ	3 √Widowed 4 Divorced	1 ☐ Yes 2 ☐ Y If Yes, Give X Year or Dates:		1 □ Ye	es 2⊠No	Specify:			Specify: Wh	ite
	ted	15. Decedent's Ed	ucation	16a	a. Decedent's	Usual Occup	ation		16b.	Kind of Business/Ir	ndustry
	Completed	(Specify only highest gra	de completed) College (1-4or 5	54)	(Give kind o	of work done o OT use retired	during most of	working			
	E	8 years	College (1-401 c	,,,	Homer	maker			C	wn Home	
	Be	17. Father's Name (First, Middle, Last)					18. Mother's I	Name (First, M.	iddle, Maide	n Sumame) Ur	nkn.
	2	Alexander Muchla					J	osephin	ne .		
	id	19a. Informant's Name/Relationship (ype, Print)	19	b. Mailing Add	iress (Street a	and Number or	Rural Route N	umber, City	or Town, State, Zip	o Code)
		Mrs. Linda Cox (I	aughter)		3 Norh			. В Ва	altimo	re, Md.	21221
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Demoval from State	20b. Place o	of Disposition ery, crematory	(Name of or other plac	θ)	Date	20c. t	ocation - City or To	own, State
		'4 □ Donation 5 ☑ Other (Specify			d Hear			2/21/20	04 ва	ltimore,	Maryland
ouce.		21. Signature of Juneral Service Licen	× 1	0///		e and Addres		I IIoma	of Dur	-d-31- T	_
a 8	1	May 191	12	4/	7922	-Ruck Wise	runerai Avenue	Dunda	lk. Ma	dalk, In	C. 1222
35		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. Do	not enter the	mode of dyin	g, such as card	diac or respirate	ory arrest,	7	Approximate Interval Between
ian		Immediate Cause (Final disease or condition		CANCER							Onset and Death
al		resulting in death)	v	a consequence							
er		Sequentially list conditions	b								
	luer	Sequentially list conditions, tary said to cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consa uence	of):						
	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.		0						
-			Due to (or as	a consequence	i oi):						
	dlcal		d								
	Physiclan/Med	IF FEMALE:	23c. If yes, outcome	of orogonous						1000	
1	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death		ic pregnancy				23d. Date of delive Month	ery Day Year
	ysic	1 ☐ Yes 2 🌠 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 🗌 Other	г (<i>specпy)</i>			_		
	F	Part II. Other significant conditions of	ontributing to death bi	ut not resulting	in the underlyin	no cause dive	on in Part I	23a	Did tobacco	use contribute to ti	he cause of death?
	d by	·	•		,						pably 4 🔀 Unknown
1	ete							_			
	Completed							- ;	Was an autopsy performed?	24b. Were auto prior to co death?	ppsy findings available mpletion of cause of
									es 2X N		2 🗆 No
	Be	25. Was case referred to medical examiner?	Hospital:			Othe		Death (Check o	100		
	10	1 ☐ Yes 2 XNo 27. Manner of Death	1 🗀 Inpatie	nt 2 ER/O	utpatient 3.	DOA	4 🗀 Nursini			6 Other (Specif	HOSPICE
	5	1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)	Year)	Injury M	28c. Injury Work		28d. Desci	ribe how inju	ry occurred	
	Certification:	2 Accident investigation 3 Suicide 6 Could not be		unu. At hama 6			fes 2□No	206 1 0 0 0 1	(Ctt-		
	Ħ	4 Homicide determined	28e. Place of Inju- building, etc	c. (Specify)	arm, street, tac	ctory, office	•	City of	on (Street a r Town, Stat	nd Number or Rura e)	al Houte Number,
		29a. Certifier X Certifying Ph	unicians To the boot o	of my kanylada	a death						
	Medical	(Check only one)	ysician: To the best of iner: On the basis of and manner sta	examination ar	e, death occur nd/or investiga	rred at the tim ttion, in my op	ie, date and pia pinion, death od	ace, and due to ccurred at the ti	the cause(s me, date an) and manner as si d place, and due to	tated. the cause(s)
	Mec	29b. Signature and title of certifier	and mariner sta	iteu.		29c. License	number		29d Da	ite signed (Month,	Day Year)
1						DI	770		234. 08	7/10	1011
			1-			レム	312]		0/18/	, , ,
	- 1	30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Print)						
4		DR. TARIQ MAHMOO	n 2200	ULANEY	***	-		M, MD 2			

5:40 a.m.

FEBRUARY 18, 2004

IDA DONOVAN

		•	1 - For State Registrar	State of M	Maryland / Dep	artmen e <i>rtificat</i>	t of H e of L	lealth a Death	and M	ental Hyg	jiene, leg. No.	2004	05708
			1. Decedent's Name (First, Middle, Las	st)						2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic		Eleanor M. Day	s						Februar	•		6:00 a ^M
	Examin		4a. Facility Name (If not institution, give	street and number	ar)	4b. City,	Town, or	Location of	of Death		4c. C	County of Dea	th
			35 Pendragon Cour					stown				ltimore	
	Funeral		5. Social Security Number 6. S	ex 7 □M 2X□F	Age (In yrs. last birthda Yrs.	Months	1 Year Days	If Under	Min.	8. Date of Birth (Month, Day	, Year)	Co	thplace (State or Foreign ountry)
	Director		213-28-6975 Usual Residence of Decedent	7.	73					9-3-19	30	MD	
	and and		10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
	Mary f sho	ō	MD Baltimon	•	Reisters	OT TO							1 ☐ Yes A No
	the 28e	Director	10e. Street and Number		Reisters	10f. Zip	Code			1	10g. Citiz	en of What Co	ountry?
	3a or		25 Dominion Co.			2.1	136				TT C	A	
	me 2	Funeral	35 Pendragon Cou	12. Was Decede	nt Ever in U.S. 13	. Was Dece	dent of H	ispanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	US/	A. Race - Ame	erican Indian,
9	after or ite		1 Never Married 2 Married	Armed Force	ZNo	1 ☐ Yes		Specify:		rican, etc.)		Black, White Specify:	e, etc.
5	ral',	d by	3 ⊠Widowed 4 □ Divorced	If Yes, Give Year or Date	s:	1 🗆 103	2 23 140	Specify.					White
Maryland 21215-0036	be filed within 72 hours after death with the Maryland all thygiene. All the West and the filed the control of other than "natural", or terme 23a or 28a-f show other than "natural", or terme 23a or 28a-f show arent, the Medical Exeminar must be notilied at	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dec	edent's Usu ve kind of wo . DO NOT u	al Occupa ork done d	ation during most	t of workir	ng	16b. Kin	d of Business	/Industry
[2	vithin ne. han	m d	Elementary/Secondary (0-12)	College (1-4d	or 5+)							7 16	ć
N.	filed v Hygie other t		8 17. Father's Name (First, Middle, Last)		ASS	embly	work		er's Name	(First, Middle.			ufacturing
auc	d tal	Be										,	
Ë	2 should be filed and Mental Hygi Is marked other aumatic event, I	٢ ا	John Dukes 19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ilina Address	(Street a	Rut and Numbe		unknos I Route Numbe		Town, State, 2	Zip Code)
<u>8</u>	nd 2 she alth and 27 is mu ir traum			ughter	476	Ronn	io R	rao P	ond 1	lkesvi	116	MA 212	Drie.
ō	Heg Heg tem othe		20a. Method of Disposition	ugitter	20b. Place of Dis	position (Na.	me of			ate		ation - City or	
9			1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		ite .	-			105.11	2004	R=1+-	imore,	MD
altimore,	그런런 중 .		21. Signature of Funeral Service Liger			22. Name a	nd Addres	ss of Facilit					
ñ	Depa Impo Impo any ii		John U.S	Mari		line	Fune	ral H	ome 1	11824 Re Reister:	eiste stown	erstown	Road 21136
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	sed the death. Do not e								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Luna	Canan								Grint months
ч	/Medical		resulting in death)	w	as a consequence of):								J.,,
	Examiner		Sequentially list conditions.	b									
	D #	luei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Colorate or Injury	Due to (or	as a consequence of):								
	and I-tran	Examiner	that initiated events resulting in death) Last	c	as a consequence of):								
8760,	ate be executed hysician and the burial-transit												
687	. Q. (n	Physiclan/Medical		_ d									
Вох	attending for use as	Z/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		-					23	3d. Date of de	livery
m	death a atter	clai	in the past 12 months? 1 ☐ Yes 2 No	4☐Pregnan	t at time of death	B⊟Ectopic p i⊟ Other <i>(s</i>)		·				Month	Day Year
o.	that the death red by the atter detached for u	hys	9 □ Unknown	9∐ Unknow	າ 				-				
ď.	res tha signed be det	by P	Part II. Other significant conditions	ontributing to deat	h but not resulting in the	underlying	cause give	en in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
ğ	v require been sig	ed	Chrone Obst	nuchivi	hung f	15ems	é			1 9 Y	es 2	No 3∏Pi	robably 4 Unknown
Records,	e law re has be ye 2 sho	ple								24a. Was a autops		24b. Were at	utopsy findings available completion of cause of
m m	The ate h page	Completed								perfor 1 ☐ Yes	med? 2√2 No	death?	2 □ No
Vital	icien: The certificate rector, pag	Be	25. Was case referred to medical examiner?	11			100		of Death	(Check only or	70)		
5	Physic this c	ို	1 Yes 2 No	Hospital:				4 🗀 190	-	ne 5 Resid			city)
n c	Attending Physicien: The is death. sctor: After this certificate haby the funeral director, page	lon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of I (Month,	njury 28b. Time Day Year) Injury	or .	28c. Injun Worl	yat k? Yes 2.∐l		28d. Describe h	ow injury	occurred	
isi	ttend death stor: /	icat	2 Accident investigatio 3 Suicide 6 Could not b		Injury - At home, farm,			163 2		28f Location (S	treet and	Number or Ri	ural Route Number,
Division of	after Direction by	Certification;	4 ☐ Homicide determined		etc. (Specify)	311331, 123,01	y, omoo			City or Tow	n, State)		
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	(Check only 2 Medical Exer	niner: On the basi	est of my knowledge, de s of examination and/or	ath occurred	at the tin	ne, date an pinion, dea	nd place, a	and due to the c	ause(s) a	and manner as place, and due	s stated. e to the cause(s)
	o the ithin (o the omple	Med	29b. Signature and title of certifier	and manner	olatou.	29	c. Licens	e number		2	29d. Date	signed (Mont	th, Day, Year)
)	F 3 F 8 □		Man Sulla	Yacar	M.D.		1)1	797	3	4	50 hr.	2000 23	2004
	λ		30. Name and address of person who	completed cause	of death (Item 23a) (Type	e, Print)	<i>U</i>	, , ,	1	1	- 014	invery 2	
	Ì		Manshil A. Levin 31. Date filed (Month, Day, Year)	ne 6569	Novila C istrar's Signature	lun los	SX.	BAH	fine	my M	ary 1	irsla	21204
	Sta Registi		FEB 2 4 2004	W.	as signature	Spark	21				127		

			i icasc	Out of Man	dend (De		ak af I la	alth and A	Apptal Hug	viono.	000		
			For State	State of Mary	yland / De	paπmei Certifica	to of D	aith and iv e <i>eth</i>			2001	+ 05	709
		4-	Registrar 1. Decedent's Name (First, Middle, Las	*1		erinca	TE OI DI	Gairi	2. Date of Dea	ith		3. Time o	of Death
	Physicia	ın			المام المام المام				Month	Day	Yeer		м
	/Medic	al -	JONATHA 4a. Fecility Name (If not institution, give	n Andrew Eb	<u>ernarqt</u>	4h Cih	Town or ic	ocation of Death	FEB.	4c. 0	2004 County of Death	111:5	u a
	Examin	er	Quail Run Assist			40. 00	Gambr					Arunde	.1
					n yrs. last birtho	lay) If Unde	er 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Dey	h		nplece (Stete untry)	
	Funeral Director		028-32-8805	7. Age (li	61 Yrs	Months	Days	Hours Min.	JUN 16.			_{intry)} i Jersi	
		-	Usuel Residence of Decedent						10011 10,				
	ylan how		10a. State 10b. County	10	0c. City, Town o	r Location						10d. Inside (Sity Limits s 2 ☑ No
	Ma-1-	cto	Maryland Anne A	rundel			brills	3					X
	or 28	Director	10e. Street and Number			10f. Z	ip Code			10g. Citiz	en of What Co	untry?	
	be filed within 72 hours after death with the Maryland at Hygiene. Is Hygiene. Is thy yield the "retural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified.	Ta l	2163 Davidsonvi				2105				USA 4. Race - Amer	ican Indian	
	se de la se	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dec If Yes, sp	edent of Hisp ecify Cuban,	Mexican, Puerto	ecify Yes or No- Rican, etc.)	` '	Black, White		
9	hours after lurei', or ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes 2 No If Yes, Give Year or Dates:		1 🗆 Yes	Ž∏ No	Specify:			Specify: W	nite	
3	hour turel		15. Decedent's Ed		16a. D	ecedent's Us	ual Occupation	on		16b. Kir	nd of Business/l	ndustry	
ς Ω	in 72	olet	(Specify only highest gra	de completed)	(C	Give kind of w fe. DO NOT	vork done dur use retired)	ring most of work	king				
212	filed within 72 Hygiene. other than "na! ent, the Medic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Sa	ales				Fo	undry S	Supply	
0	Hygi other	BeC	17. Father's Name (First, Middle, Last)				1		e (First, Middle,				
ā		To B	Charles Richa	rd Eberhard	t			Doro	thy Eliz	zabet	h Mack		
Maryland 21215-0036	d 2 should the and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. N	lailing Addre	ss (Street and	d Number or Ru	ra <i>l Route Numbe</i>	r, City or	Town, Stete, Z	ip Code)	
	C = 01 L		Amy B. Lorenzo/Pe					Road W	hite Hal		D 21161		
ore Ore	iges 1 and of Healt if item 2 or other		20a. Method of Disposition 1 Burial 2 Cremation 3			crematory or	r other place)		Date		cation - City or		
Ĕ	Pages ment of ant: If it ury or o		*4 □ Donation 5 □ Other (Specif		Metro ($nc \cdot 2/2$			timore,	MD	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice	My comal					of Maryl				
	20E 3 0		Dawn F. Mc	Donald	- dash Dasa	299 F	rederi	ck Road	Baltim	ore,	MD 212	228 Approxima	ate
			shock, or heart failure. List only	one cause on each line.	e death. Do no	3		,	1	/	600	Interval Be Onset and	etween
	Physician		Immediate Cause (Final disease or condition resulting in death)	171HaST	4100		aurr	MASK	9 10 Mg	TO.	DIEIN	7	450
П	/Medical Examiner		Tooling in assum,	Due to (or as a c	onsequence of)	:			/				/
Н		10	Sequentially list conditions,	b. Due to (or as a c	consequence of)	:				-			
	ted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	be executed sictan and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence of)	:							
760		cai	(d									
9	tificate g phys as the										}		
Box	eath certific attending pl	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		3 Ectopic	pregnancy			2	3d. Date of deli Month	very Day	Year
m m	deat	sicis	in the past 12 months? 1 🗆 Yes 2 🗆 No	4 Pregnant at tin		5 Other (NOTE	Day	Tour
<u>о</u> .	at the	Physician/Med	9 Unknown					in Dard I	220 Did to	2b2000 H	se contribute to	the cause of	f death?
	n requires that the de been signed by the s should be detached	by	Part II. Other significant conditions	contributing to death but i	not resulting in t	ne ungenying	g cause given	in rani.		(es 2[obably 4	
ord	requii	Completed								-			
ec	law lasb	npie							24a. Was autop	SY	24b. Were au prior to 4 death?	topsy finding completion of	cause of
H	The	S		,					1 ☐ Yes	rmed? 2 No	1 🗆 Yes	213 No	
Vital Records,	ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:			Other		th (Check only o		Y	Assi	sted
of	Physical this call direction	To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outp		28c. Injury a	4 Nursing	ome 5 Resid				ng
LO	ding After	tion	1 Natural 5 ☐ Pending	(Month, Day Y	(ear) Inj	ury M	Work?	es 2 No					
Division of	deatl deatl ctor: y the	fica	3 Suicide 6 Could not b	e 28e. Place of Injury		n, street, fact	ory, office		28f. Location (S			ral Route Nu	ımber,
<u>S</u> .	after Direction Direction by	Certification:	4 Homicide	building, etc.	(Specify)				City or Tox	vn, State,	,		
	To the Hospital or Attending Physicien: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier Sertifying P	nysician: To the best of	my knowledge,	death occurre	ed at the time	o, date and place	, and due to the	cause(s)	and manner as	stated.	2(c)
	n 24 ł n 24 ł ne Fu	Medical	(Check only 2 Redical Exa	miner: On the pasis of e and manner state	xamination and/ ed.	or investigati	on, in my opii	nion, death occu			1		
	To the To the Comp	Σ	29b. Signature and title of certifier	011.1.	1 22		29c. License	number		29d. Dat	e signed (Monti	n, Day, Year)	
	า		Mimarch	THUMU	00		リウ し	0014		a	100/2	14	
	//		30. Name and address of person who	completed cause of dea	(Item 23a) (T	ype, Print)	InnT	20 /	ME 30	ックー	Tomes	nmo	71704
			Bichard L. + 145	11G 71750	1500	diam's all	IVI	IK, SU	116 7	4	10000		0.01
3.3	Sta	ate	31. Date filed (Mant Lay, Kears &	and a supplied	Soud Bring	0	,						

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4:35 am Marvin E₁y P CO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 90 Baltimortimore Sihai hospita If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**★** M 2□ F 220-09-6750 82 Yrs. 11/18/21 Director Maryland Usual Residence of Decedent e filed within 72 hours after death with the Manyland at Hygiene. other than "natural", or items 23s or 28s-1 show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or itams 23s or 28s-1 show other traumatic event, the Medical Exampler must be notified at 1 ☐ Yes 2 X No Director **Baltimore** Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6604 Windsor Mill Road 21207 U. S. A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1€ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No White Specify: Be Completed by 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Lineman Baltimore Gas & Electric 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) should be Health and Mertal John Walter Pauline Alberta Vomastek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Chris Ely Son 17161 Alva Road, #2724, San Diego, CA. timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State rtment of h rtant: If its njury or o 1 Burial 2 Cremation 3 Removal from State Lorraine Park Cemetery 02/20/04 Woodlawn, Maryland 21207 * 4 ☐ Donation 5 ☐ Other (Specify) pernit. Depertminimperta 21. Signature pr Funeral Service Licensee 22. Name and Address of FacilityLoring Byers Funeral Directors Inc Bai 8728 Liberty Road, Randallstown, Md. 21133-4784 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. End underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician ar P.O. Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 Yes 2 No 3 Probably 4 Dunknown as been signal 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? page 2 🔼 No certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification; Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Diractor:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1700 p. tx1 Ryan C. W. Hall Sinan 32. Registrar's Signature 31. Date filed (Month, Registrar

		1 - For Stata Registrar		State of I	Marylan			of Health of Death			Reg. No	2004		
Physici		Decedent's Name (F) FRANK	First, Middle, Last) LIN D. E'	VERDING						2. Date of Dea Month	Day	31 200	3. Time of 0	Death DAM
/Medic Examin		4a. Facility Name (If not	-			SPITAL		wn, or Location				County of Deat		
Funeral Director		5. Social Security Numb 212-12-246	ber 6. Sex			last birthday) Yrs.	If Under 1 Y	ear If Under Hours	Min.	8. Date of Birt Month, Da 5/24/19	h y, Year) 2 1	9 Rin	hplace (State or buntry) RYLAND	Foreign
pu *		Usual Residence of Dec 10a. State 10	cedent b. County		10c Cit	y, Town or Lo	cation						10d. Inside City	/ Limits
a-f shov	ctor		BALTIMOR								1 □ Yes 2 🟋			
with the	i Dire	10e. Street and Number		A DOT O	00		10f. Zip Co					izen of What Co	ountry?	
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 te marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Exhibiter must be multified at	Funeral Director	Armed Forces?											ncan Indian, e, etc.	
ral', or	þ	1 Never Married 3 Widowed 4		1 X Yes 2 (If Yes, Give Year or Date	s:WWII		1 ☐ Yes 2🔯	No Specify	:				HITE	
hin 72 h 3. In "natu Medical	Completed	15. (Specify of Elementary/Seconda	Decedent's Educionly highest grade	ation completed) College (1-4d	or 5+)	(Give	tent's Usual O kind of work o DO NOT use n	one during mo	st of worki	ng	16b. Ki	ind of Business/	industry	
2 should be filed withir and Mental Hygiene. Is marked other than sumatic event, the Me	Com			YEARS		MANA	GER					JE - AT&	T	
be file d oth	Be	17. Father's Name (Firs		TNG CD						(First, Middle,	Maiden	Sumame)		
i Men i Men narke	မ	FRANKLIN	-		•	401 44 7			/A LE			T 0		
12 sh h and 7 le n traun		19a. Informant's Name. LUCILLE M.			WIFE			COURT				or Town, State, 2		2
1 and Health em 27 ither tr		20a. Method of Disposit		<u> </u>	20b. F	Place of Dispo	sition (Name o	of		ate		ONTUM, Mocation City or)
Page nent c ant: # ury or		1 ☐ Burial 2 🖾 C 1 ☐ Donation 5 ☐	remation 3 Re	moval from Sta	IA I		natory or other	, INC.	2/23	/2004	CAI	ONSVILL	E, MD	
permit. Departr Imports any inj		21. Signature of Funera	al Service License	-				ddress of Faci CH RAVE	1111				HOME, P 1286	.A.
	4	23a: Part1. Enter the d shock, or heart fa Immediate Cause (Fina	disease, or complic filure. List only one at	ations that cause on each	sed the deat n line.	2	1 *						Approximate Interval Betwee Onset and De	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Iulmonary Disease Due to (or as a consequence of):									٤	years		
Examiner	Į.	Sequentially list conditi	ions, b.	Due to (or	as a conseq	uence of):								
cuted	Examiner	cause. Enter Underlyin Cause (Disease or inju- that initiated events	ng Iny 1	20010 (0.										
te be executed ysician and te burial-transit	cal Ex	resulting in death) Last		Due to (or	as a conseq	uence of):								
ficate phys s the			d .											
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nths?	c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 □ Feta tat time of d	Ideath 3□	Ectopic pregr Other <i>(specil</i>					23d. Date of deli Month	ivery Day Ye	par
puires that n signed b		Part II. Other significan	nt conditions cont	ributing to deat	but not res	ulting in the u	nderlying caus	e given in Part	1.		obacco u es 2[the cause of dea	
sician: The law rec certificate has bee irector, page 2 shou	Completed									24a. Was autop perfor		prior to d	topsy findings av completion of cau	railable
Physician: this certificatal director,	Be C	25. Was case referred examiner?	-	aniasi k				1	e of Death	(Check only o				
his his	ို	1 ☐ Yes 2 No	Ho			ER/Outpatien						6 Other (Spec	cify)	
inding Physician: ath. ir: After this certifica ne funeral director,	ation:	27. Manner of Death 1 Natural 5 2 Accident	☐ Pending investigation	28a. Date of I	njury Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes 2		28d. Describe h	iow injur	y occurred		

To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funerel Director: After completely filled in by the funera

State Registrar

Medical Certification

31. Date filed (Month, Day, Year)

3 Suicide 4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one)

6 Could not be determined

ripleted cause of death (Item 23a) (Type, Print) Ghazinoun 32. Registrar's Signature

Geriatric Center and Hospital DOCKS

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D00 60 170

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registra 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 48 A M Theresa Felton Feb. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NIA University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthpface (State or Foreign Country) **Funeral** 1 □ M 2 🖸 F 75 Dec 10, 1928 Spotsylvina Va Director 577-42-1627 Usual Residence of Decedent County the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow Examiner count be notified at 1 Yes 2 □ No Director DCWashington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States ітетя 23а 306 Randolph P1 NE 20002 Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bfack, White, etc. 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 *natural', or 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed by 3 N Widowed 4 □ Divorced or than "nature 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Efementary/Secondary (0-12) Colfege (1-4or 5+) Health Care Tech Government 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental Henry Stubbs Lottie Woodfork 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tra Duery C. Felton Jr./ Son 306 Randolph P1 NE Washington DC 20002 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State F 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Washington National 2/20/2004 Suitland * 4 ☐ Donation 5 ☐ Other (Specify) Cemetery_{22 Name and Address of Facility}
Alexander S. Pope Funeral Home Signature of Funeral Service Licensee 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** right middle cerebral artery stroke 0 days /Medical Due to (or as a consequence of) Examiner 109 Due to (or as a consequence of) weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last ang Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed hear ongestive weeks Due to (dr as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medicai weeks acute rena IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Unknown brillation 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan diabetes has autopsy performed? certificate 1 Yes 2⊠ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 SNatural Injury 5 Pending 1 🗌 Yes 2 🗆 No death. investigation 2 Accident Director: 6 Coufd not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after de Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) 4176435 MD -eb. 14 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lee, MD 22 South Greene St. Baltimore, MD Angela 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State 2 200 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year Margaret Zilpha Fogerty February 20, 2004 3:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Wesley Home, Inc. Baltimore N/A8. Date of Birth (Month, Day, Year) April 22, 1916 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F 149-09-2422 87 Yrs. Director Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show It e Madical Examinar must be notified at Maryland N/A Y∑Yes 2 ☐ No Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2211 W. Rogers Avenue 21211 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 270 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specity: Specify: δ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Store Keeper Salvation Army of Health and Mental Hygie I item 27 Is marked other i r other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Carroll Jennie Carev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Breen Daughter 2604 Manhattan Avenue Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Pk 2/26/04 * 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD 21. Signatus Juneral Service Lifens ^{22, Name and Address of Facility}
Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211 Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failing. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMER'S DEMENTIA Physician END-STAGE /Medical Examiner Sequentially list conditions, if any, leading to infraedate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by certificate has been signe rector, page 2 should be 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certified to completely filled in heart. 1 Yes 2 No 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🗙 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-19425 02-21-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ro By M.D. - ZZII W. ROGERS AVE- BALTIMORE, MD E. 31. Date filed (Month, Day, Year) -- -32. Register's Signature State Registrar

		•	For State Registrar	State o	of Maryland	d / Depa	artment of H	lealth a Death	and M	ental Hy	giene Reg. No.	2004	05714
	Physici		Decedent's Name (First, Middle Anna	a, Last)		Fento	n			2. Date of De Month Februa	eath Day	Year 2,2004	3. Time of Death 7:55 P M
>	/Medic Examin		4a. Facility Name (If not institution Genesis Elderca				4b. City, Town, or Dundalk			I CDI GG	4c.	County of Death	1
	Funeral Director		5. Social Security Number 219–32–0641	6. Sex 1 ☐ M 2 🂢 F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da December	th ay, Year) 1 23,1	9. Birth Cou M	nplace (State or Foreign untry) D.
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD. N	-/A	10c. City	, Town or Lo	cation more City	7					10d. Inside City Limits 1 ¬Yes 2 □ No
	th with the 23e or 28e	al Director	10e. Street and Number 326 South Robin	son Stree	et .			224				zen of What Col	
36	irs after dea il', or items zaniner m	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed F	2X No	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes	ispanic Or in, Mexical Specify:		cify Yes or No Rican, etc.)		A. Race - Amer Black, White Specify: Whi	, etc.
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28e-1 show other treumatic event, the Medical Exam entire treumatic event,	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)						st of worki	ng	16b. Kind of Business/Industry		ndustry
and 21	d be filed wantal Hygier ced other the cevent, the	Be	9 years 17. Father's Name (First, Middle, Gilman Fenton	Last)		Custo	mer Servi	18. Moth		(First, Middle	Bar , Maiden		
	1 and 2 should the Health and Ment tem 27 is marked other treumatic	2	Gilman Fenton Lula C. Imhoff 19a. Informant's Name/Relationship (Type, Print) Sharon Barnes niece Lula C. Imhoff 19b. Mailing Address (Street and Number or Rural Route Number, City or 326 South Robinson Street, Baltimo										
altimore,	9 1 = P		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	n State	emetery, crei VV ie W	sition (Name of natory or other place Crematory	7	Febru 23,	2004	Balt	cation - City or 1	City,MD.
Ball	permit. Pa Departmer Importent: any injury once.		21. Signature of Funeral Service 21. Signature of Funeral Service 23a. Part1. Enter the disease or	C. C	mell	4/17	Name and Address Onnelly F	ers Po	oint.	Road, D	unda.	alk,P.A. lk,Md.	21222 Approximate
V	Physician /Medical Examiner	Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to	each line. O (or as a consequence of the consequen	IVE Jence of):	HEAR ILLAT	OK	FAK	CRE			Interval Between Onset and Death
k 68760,	ertificate be executed ing physician and e as the burial-transit	edlcai	that initiated events resulting in death) Last	d	o (or as a consequ	zence of):							
.O. Box	that the death certifics ed by the attending pt detached for use as t	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregna birth 2 Fetal gnant at time of de nown	death 3	Ectopic pregnancy Other (specify)	· · · · · · · · · · · · · · · · · · ·			2	23d. Date of deli Month	very Day Year
σ	w requires that the been signed by th should be detache	þ	Part II. Other significent condition	ons contributing to	death but not resi	ulting in the u	nderlying cause giv	en in Part I	l.		tobacco u Yes 2		the cause of death?
Vital Records	The la ate has page 2	Completed								24a. Was auto perfo 1 \(\text{Yes}		24b. Were aut prior to o death? 1 \(\sum Yes\)	topsy findings available ompletion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:			Oth	or		(Check only			
	ding h. After fune	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date (Mo.	Inpatient 2 e of Injury nth, Day Year)	28b. Time o Injury	28c. Injur Wor	y at	2	28d. Describe		Other (Spec	<i>ity)</i>
Division of	or Atten ifter deal Director: in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	ce of Injury - At ho ding, etc. (Specify	ome, farm, st	eet, factory, office		1	28f. Location (City or To			ral Route Number,
	the Kospitel nin 24 hours a the Funerel I npietely filled	edical (29a. Certifier 1 Certifyir (Check only one) 1 Medicel	ng Physician: To the Examiner: On the and ma	ne best of my kno basis of examina nner stated.	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date ar pinion, dea	nd place, a ath occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complete	M	29b. Signature and title of certifie	10 July	K HI)	l	29c. Licens	e number	88		29d. Date	23/69	, Day, Year)
	3		Swindy	who completed cau	421	23a) (Type,	Vet 8	ecc	1)	unflet	K,	HO.	2)222
	Sta Regist		31. Date filed (Month, Day, Year)	04	Registrar's Signa	(Ure	look!						_

			1 - For State Registrer	State of Marylan		artment of I			Reg. No.	4 05715	
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last) JOSEPHINE		·	FRATII	V /	2. Date of De Month FEBRUA	Day Yea	041.13 PM	
	Examin	er	4a. Facility Name (If not institution, give s HARBOR HOS	SPITAL		BALT If Under 1 Year	IMOI	RE	N/	Ä	
	Funeral Director		170 10 0902	7. Age (In yrs.	Yrs.	Months Days		n. (Month, D.	15, 1914	Birthplace (State or Foreign, Country) Italy	
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County	1	y, Town or Lo					10d. Inside City Limits 13€ Yes 2 □ No	
	r 28a-f	recto	Maryland N/A 10e. Street and Number		altimo	10f. Zip Code			10g. Citizen of What Country?		
	23a o	ral D	3809 Fifth Stree			212			U.S.		
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show simportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaluation made indiffications.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub		(Specify Yes or N erto Rican, etc.)	Specify: W		
215-0	ithin 72 ho ne. nen "natur Medical	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)	cation e co <i>mpleted)</i> College (1-4or 5+)	dent's Usual Occu kind of work done DO NOT use retire rdresser	during most of wed)	rorking	16b. Kind of Business/Industry Beauty Shop			
Maryland 21215-0036	should be filed wand Mental Hygiels marked other ti	To Be Co	6 17. Father's Name (First, Middle, Last) Nazzaren	o Fratini			18. Mother's N	ame (First, Middle ana Sabba	, Maiden Surname)	ПОР	
Mary	id 2 should be th and Mental 27 is marked of traumatic ev	-	19a. Informant's Name/Relationship (Type Cheryl Richards			ng Address <i>(Stree</i> halmers			oer, City or Town, State rnie, Mary	e, Zip Code) land 21061	
ore,	of Health of Health fitem 27		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R		Place of Dispo cemetery, crea	osition (Name of matory or other pla	ace)	Date	20c. Location - City		
Baltimore,	permit. Peges Department of I Important: If its any injury or o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Но		ss Cemeto			Baltimore meral Servi	e, Maryland	
Ba	permit. Departr Importa any inji		Jana MZ	raminalis	hi 40	001 Ritch	nie High	vay Bal	Ltimore, Ma	aryland 21225	
	Enysician		23a. Part 1. Enter the disease, of copolishock, or heart failure. List enty or Immediate Cause (Final disease or condition resulting in death)	ications that caused the deat ne cause on each line. ACUTE	h. Do not en	ter the mode of dy		FARCT		Approximate Interval Between Onset and Death	
8760,	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) co	RY juence (1):	ARTE	RY	DISEA	15E	2 YEARS	
.O. Box 68	The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as it	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	I death 3[□Ectopic pregnand □ Other (specify) _	ey .		23d. Date of Month	delivery Day Year	
۵.	quires that n signed b uld be deta	d by Pl	Part II. Dther significant conditions con CONGESTIVE H	ntributing to death but not res	culting in the u		ven in Part I.	_		e to the cause of death? Probably 4 □Unknown	
Vital Records,	The law rec te has bee age 2 shor	omplete	PRACTION 10%	DIABETES	ME	LLITUS	5	24a. Was			
lta.	ician: The certificate rector. pag	BeC	25. Was case referred to medical examiner?					eath (Check only			
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	ို	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	lospital: 1 X npatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju		-	idence 6 Other (S	ipecify)	
Division of	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special					(Street and Number cr wn, State)	Rural Route Number,	
	Hospite 24 hours Funerel elely filler	edical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tovestigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s) and manner date and place, and d	as stated. due to the cause(s)	
	To th within To th compl	Me	29b. Signature and title of certifier	- A11	-		se number		29d. Date signed (Mo		
)	1.		Jarania	- MD			5001		FEBRUARY	172004	
	V		30. Name and address of person who or JANAKI DEEPAK 3		ANOVE	R STREE	ET, BA	LTIMOR	E, MD	21225	
	Sta Registi		31. Date filed (Month, Day, Year) FFR 2. 4 2004	32. Registrar's Sign	ature	A.S.					

State of Maryland / Department of Health and Mental Hygiene 2004 05716 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 9.35pm **Physician** OUL 20 tar bar han /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner RUXTON PIKESVILLE NURSING HOME BALTIMORE PIKESVILLE 7. Age (In yrs. last birthday) If Under 1 Year | ff Under 24 Hrs. Birthpface (State or Foreign Country) 8. Date of Birth (Month, Day, Year) SEPT. 28, 1908 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2 □ F Yrs. 95 POLAND 107-30-2078 Director Usual Residence of Decedent with the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No PIKESVILLE Directo BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 U.S.A. 7 SUDBROOK LANE death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritaf Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4or 5+) SALESWOMAN S. KLEIN DEPT. STORE other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any july or other traumatic event 9068. Be SORGEN DORA LERNER SHLOMO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6350 RED CEDAR PLACE #404 - BALTIMORE, MD 21209 MAE NETTLER / DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 2/23/2004 * 4 ☐ Donation 5 ☐ Other (Specify) SHARON GARDENS CEM. VALHALLA, NY 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com-shock, or heart failure. List only pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) Years **Physician** Neimeria SPase /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760 physicien Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 1 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has autopsy certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4√ Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2₩No 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Infury 1 ∰Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after To the Hospital within 24 hours a To the Funeral C Hospital 1🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 21,2004 D 37573 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 V9015 Reistrustown MD 21136 Main 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 4 2004 souls Registrar

DHMH 17 Rev 1/2001

FEBRUARY Baltimore.

Box 68760.

MACKARTHUR FORTUNE

Stom	n Frasie	er	Please	Type or Print in	Black I	ndelible Inl	k. Ensure A	All Conies A	re l egible	
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RJ _			1 - For Amerid & Unpend Registrar		8a-i per	entificate of	Death Tels	Reg	J. No. 200	4 05718
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Death Month February	20, 2004	3. Time of Death
	/Medic Examin		STORM A. FRAS 4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deatl		4c. County of Dea	
Ch			St. Agnes Hospita				ltimore			NA
B	Funeral Director		5. Social Security Number 6. S 212-69-4958 Usual Residence of Decedent	ex 7. Age (In yr	rs. last birthday	Months Days 2 3		8. Date of Birth (Month, Day, Y	ear) C	thplace (State or Foreign ountry) MD
	Maryland a-f show	ctor	10a. State 10b. County MD NA	10c. (City, Town or I	ocation ALTIMORE				10d. Inside City Limits 1 X Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
	eath v	era	38 HILLSDALE RO	OAD 12. Was Decedent Ever in	116 12	Mas Doordoot of	21207 Hispanic Origin? (S	=== 4. V == == N =	USA 14. Race - Ame	to disconnection
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, Ite Medical Examinal must be notified at once.	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	0.3.	If Yes, specify Cu 1 ☐ Yes 2 1 No	ban, Mexican, Puert	o Rican, etc.)	Black, Whit	
2-0	72 ho 'natur	eted	15. Decedent's Ed (Specify only highest gra		16a. Dec	edent's Usual Occu	upation e during most of wor	kina 16	b. Kind of Business	
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir	ed)	9		
Jd 2	e filed al Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)	0		NONE	18. Mother's Nan	ne (First, Middle, Ma	iden Sumame)	E
yla.	ould b	10	CLIFF FRASER						DMONDS	
Maryland 21215-0036	id 2 sh Ith and 27 Is m traum		19a. Informant's Name/Relationship (7) RENEE GORSHAM (GRA					rai Route Number, C		122
	of Heal		20a. Method of Disposition	20b.	. Place of Disp	SOUTHLA osition (Name of imatory or other pla		BALTIMORE 20	MD 212: c. Location - City or	
Baltimore,	Page Iment Iant: If jury or		1 ☐ Burial 2 🛣 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify) <u>M</u>		REMATORY	2/26	7/04 CA	TONSVILLE	MD
Ball	permit Depart Impor any in		21. Signature of Funeral Service Licen	See .	2	2. Name and Addr		WYLIE FUNI		
#	MERCE	***	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the de	ath. Do not er	ter the mode of dy	ILMOR STR ing, such as cardiac	LET BALT	IMORE, MD	21217 Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,			Onset and Death				
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3760,	ate be executed nysician and he burial-transit	icai Examin	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
Division of Vital Records, P.O. Box 68760	or Attending Physiclan: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physicia in by the tuneral director, page 2 should be detached for use as the buri	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnand □ Other (specify) _	ey		23d. Date of del Month	iv ery Day Year
rds, P.	quires that the de	Ď	Part II. Other significant conditions co	ontributing to death but not re	esulting in the i	inderlying cause gi	ven in Part I.	23e. Did tobac	L.	the cause of death?
Reco	The law requireste has been sinage 2 should I	Completed						24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
/ital	clan: ertifica ector, j	Be	25. Was case referred to medical examiner?					1 Xes 2 \(\text{h}\) (Check only one)	190 19185	2 140
of	Physic this c	2	XXYes 2 No 27. Manner of Death	28a Date of Joiusy	ER/Outpatie	" SEL DON		ome 5 Residence		city)
ision	To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	Found 2/20/04	Injury unknown	M 1 [Yes 2 XNo	unknown		(Q
Div	afor / s after al Dire	Certi	4 Homicide - determined	28e. Place of Injury - At l building, etc. (Spec found at home		rest, raciory, ornes		28f. Location (Stree City or Town, S Baltimore N	tate) 38 Hillva	ale Road
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (29a. Certifier 1 ☐ Certifying Phyone) 2 ☑ Medical Example	rsician: To the best of my kniner: On the basis of examinand manner stated.	nowledge, deal	h occurred at the ti vestigation, in my	me date and place	and due to the caus	of and manage as	stated to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier Joushon A	Geerberg	Ma	29c. Licen:			Date signed (Month	
		1	30. Name and address of person who c	ompleted cause of death (Ite	em 23a) (Type,	Print)				
			Tashar Zaree (31. Date filed (Month, Day, Year)		noture.	111 Pei	nn Street,	, Baltimor	e, Maryla	and 21201
	Stat Registra		TO 9 A 200A	32-Registrar's Sign	g Ad	rocks				

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 23 **Physician** February 2004 Catherine Mary Grove 10:49 A.M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner **Baltimore** Charlestown Baltimore Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeb) | Feb. 24, Yeb 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday Birthplece (State or Foreign Country) **Funeral** 1□M 2 F 215 12 9844 82 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral', or iteme 23a or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code HR 111 719 Maiden Choice Lane 21228 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 XWidowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. item 27 is marked other than Data Clerk Social Security 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Karl Wiesner 2 Katherine Braun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jo Garreis / Daughter 129 Severn Way Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. 1 Burial 2 Cremation 3 Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cem. 2/26/2004 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Pak1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, is also the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien for use as the buria ivision of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2X No the 9 Unknown 9 Unknown igned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 99 anencio 2/1 No 1 🗌 Yes 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 Yes 2 1 No or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2/☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Jursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending investigation within 24 hours after use....
To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 00020040 D Choice Case 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) vall 31. Date filed (Month, Day, Year) 3. Registrar's Signature State Registrar 2 4 2004

		•	For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H	eaith and Me Death	ntal Hygie	ene 2004	05720
	(c.		Decedent's Name (First, Middle, Last)				2	. Date of Death Month	Day Year	3. Time of Death
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	Examin		4a. Facility Name (If not institution, give str	c 211.		4b. City, Town, or	Location of Death	:1	4c. County of Death	
L			5. Social Security Number 6. Sex	of Balti	1 41	Balti If Under 1 Year		. Date of Birth	9. Birth	place (State or Foreign
	Funeral Director		0. 000	M 2□F 85	Yrs.	Months Days	Hours Min.	JULY 28,	ear) Cou	RYLAND
	D.		Usual Residence of Decedent		y, Town or Lo	oation				10d. Inside City Limits
	anylar ahow	2	MD N/A	Toc. Cit		IMORE				1 Yes 2 No
	28a-f	recto	10e, Street and Number			10f. Zip Code		10g	. Citizen of What Cou	ntry?
	be filed within 72 hours after death with the Maryland ital Hygiene dother than "natural", or flema 23a or 28a-f ahow avant. The Medicial Exaturar must be motified at	Funeral Director	6402 ELRAY DR., APT	Γ. E		21209	9		USA	
	ema 2	ner	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H	ispanic Origin? (Speci in, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ameri Black, White	
9	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates:		1 □ Yes 2 🕅 No	Specify:		Specify: WH	ITE
-00030	72 hours after natural, or Ite		15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	ation		b. Kind of Business/Ir	ndustry
<u> </u>	within 72 iene. r than "nu	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of working 1)		WN HOME	
7	filed wit Hygiene Sther the	Con	12		HC	MEMAKER	18. Mother's Name (
	ntal H ed oth	Be	17. Father's Name (First, Middle, Last) MELVIN	HESS	:		ROSE	i irsi, iviiddie, ivia	LAZENSKY	
Ž	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a <u>once.</u>	2	19a. Informant's Name/Relationship (Typ			ng Address (Street	and Number or Rural I	Route Number, C	City or Town, State, Zi	o Code)
Ma	and 2:		STEPHEN GARY (SON)		11709	FARMLAN	D DR. ROC	KVILLE,	MD 20852	
ore,	of He of He fitam r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	Chata	cemetery, crei	osition (Name of matory or other place			c. Location · City or T	
altimor	Pages ment of tant: If it jury or o		`4 Donation 5 □ Other (Specify)	Al			K AMUNO) 2		BALTIMO	
gall	permit. Departimport any inj once.		21. Signature of Funer Service License	a			ss of Facility SOL TERSTOWN R		IN & BRUS. ESVILLE, M	
	*		23a. Part1. Enter the disease, or complic	ations that caused the deal						Approximate Interval Between
	Physician		shock, or heart failure. List only one Immediate Cause (Final	3 cause on each line.						Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consec	quence of):	, ,,,,			*	1- 10-11-5
i,	Examiner	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	woman of):					
	bed nsit	nlne	Cause (Disease or injury	Due to (or as a consec	(dence or).					
,	execu in and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):			_		
8760	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d.							
9	ertifica ling pt	Med	IF FEMALE:	20 If you outcome of orage	2004				004 Date of dalls	
Вох	leath certific attending pl	Physician/Me	in the past 12 months?	3c. If yes, outcome of pregn 1□Live birth 2□Feta 4□Pregnant at time of c	al death 3	☐Ectopic pregnancy ☐ Other (specify)	1		23d. Date of delin	Day Year
P. O.	that the de led by the a detached t	nysic	1 ☐ Yes 2 ██No 9 ☐ Unknown	9□ Unknown						
	res that signed b	by P	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	underlying cause giv	en in Part I.		cco use contribute to	
ord	w require been si							1 Yes		bably 4 □Unknown
ec	has be	Completed						24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
a	ician: The certificate rector, pag		OS IN estared to modern				00 Plans of Dank	1 Yes 2	□ No □ 1 □ Yes	2 No
₹	aiciar s certil lirecto	To Be	25. Was case referred to medical examiner?	ospital: 1 1 npatient 2	ER/Outpatie	nt 3 DOA Oth	26. Place of Death		ce 6 □Other (Spec	ifv)
J Of	Attending Physician: ir death. scior: After this certifics by the funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		y at 28	3d. Describe how		
Sior	ttendin death. stor: Af	catic	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	24 1 1 1 (24		1 Courte March Co.
Division of Vital Records,	of or Attending after death. Diractor: After din by the funer	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, st ify)	reet, factory, office	28	City or Town,	et and Number or Ru. State)	rai Houte Number,
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page			sician: To the best of my kn						
	To the Hospital within 24 hours: To the Funeral completely filled	Medical	(Check only 2 Medical Examir one)	ner: On the basis of examin and manner stated.	ation and/or ir	nvestigation, in my o	opinion, death occurred			
	To t with To t	Σ	29b. Signature and title of certifier	118 11.		29c. Licens	se number		d. Date signed (Month	, Uay, Year)
	Øì		1000			Print)	2 000		edmony 1	1,204
	10		30. Name and address of person who co	impleted cause of death (Ite		M.D.	Sina: Ho	spital	of Bal	. Homore
ı	_ , St	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	·					
4	Regist	trar	ern o 4 s	non le	Est	Acres 18 0				

ORIGINAL

Patient known of

State of Maryland / Department of Health and Mental Hygiene 2004 05721 1- StateAmend Items 24a,25,26,27,29aper Dr.,G828,024,24,04dbbbeath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Wiley Griffin February 3, 2004 12:38 PM /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 539 Cumberland Street Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1₽M 2□F 2-34-46-4563 66 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or tieme 23a or 28a-1 ehow emy injury or other traumatic event, the Michical Examinar must be notified at once. 1. Yes 2□No BAITIMORE Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21217 CUMBER LAND USA Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk unk 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BCHCR Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Baltimore City Police Dept 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Service Licensee Royald S. Wade, Director 22. Name and Address of Facility tate Anatomy Board 655 W. Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 08 /Medical Due to (or as a consequence of): **Examiner** V 12 Social transfer of the second transfer of the Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? res 22. No certificate 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient Medical Certification; To 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeref Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EUTAW PC, BACTIMORE 2425 TER 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State Registrar 2004

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 0572

				•	Certifi	cate of	Death		Reg. No. 2 U	04	05	123
	Dhycini	20	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	eeth Dey	Voar	3. Time of	
and of	Physicia /Medic		DONALD BENJAM				4b. City, Town, or	2 -			9:07	AH
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н	Funeral Director			M 2□F 56	Yrs. Mo	onths Deys	Hours Min.		4, 1947	Maryl		
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	ahow	٦	10a. State 10b. County		•					100.	1 ☐ Yes	
	28e-1	Sc.	Maryland Baltimor	'e La	tonsville	Of. Zip Code			10g. Citizen of V	What Country		
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	me 23	Funeral Director		12. Was Decedent Ever in U	J,S. 13. Was		lispanic Origin? (S en, Mexican, Puer	pecify Yes or No		e - American		
20	within 72 hours efter death with the Merylend ene. than "natural", or items 23a or 28e-f ahow ha Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Merried	II TUS, GIVE	967-	s, specify Cub ∕es 2l∑(No	en, Mexican, Puer Specify:	to Hican, etc.)	Specify	ck, White, etc	Whit	.e
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yla		2	Donald Benjamin H					a Casci				
Nar	~ ~ ~ ~	- 4	19a. Informant's Name/Relationship (Ty) Virginia C. Haine				and Number or Ru noice Lan					2122
e,	Healt m 2		20a. Method of Disposition		Place of Disposition		ioice Lan	Date	Catons 20c. Location -			21220
Baltimore, Maryland 21215-0020	permit. Peges 1 an Department of Heal Important: If Item 2 any Injury or other once.		1 ☐ Burial 2 ☒ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery, cremator tro Crema	y or other pla	-	2-23-04		imore,		
alti	Departm Departm mporta any Infu		21. Signature of Funeral Service License	36	22. Na	me and Addre	ss of Fecility Society	of MD				
Ω	8 % E 2 8		Edward A. Gr	regorchik			rick Roa		timore,	MD 21	.228	
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	GI BLEED								
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c	X X		30. Name end address of person who co	mpleted cause of death (Ite	m 23a) (Type, Print	DALC A	643 Leene 51	10	2011	· M	101	14/
(U		WEN-YEE TSAI	0.00	/(JIV. U-K	eenest	Keet E	14 CHIMUR	9, 111)410	LI/
	Sta	100	31. Date filed (Mont Papyeg) 4 2	004 32. Régistrar's Sign	ature	MES						

		•	1 - For State Registrar	State	of Marylar	nd / Depa	artmen rtificat	t of H e of L	ealth a Death	and M		giener Reg. No.	2004	057	24
		•5	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	ath Day	Year	3. Time of	1000
П	Physici /Medic		Sharon Frances	Hoffman							Feb.	21,	2004	2:00	Дм
*	Examin		4a. Fecility Name (If not institution,		umber)				Location o	of Death			County of Deet	h	
			8346 Peachwood		- A //-	to as hint do at	Jes If Under		If Under :	24 Hrs	8. Date of Bir		ward	halana (State o	r Foreign
	Funeral Director		5. Social Security Number 217-46-4522	5.Sex 1 □ M 21X1 F	7. Age (In yrs 58		Months		Hours	Min.	(Month, Da	y, Year)		hpiece (State o untry) Maryland	
	D *		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside Ci	ity Limits
	Maryla fed at	ō	MD Howard	l		essup								1 ☐ Yes	2 ⊠ No
	1 the	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of What Co	untry?	
	h with		8346 Peachwood	Road			2	0794				USA			
	deat	Funeral	11. Marital Status	12. Was De	cedent Ever in torces?	J.S. 13.	Was Dece	dent of Hi	ispanic Origin, Mexican	gin? (Spe	city Yes or No Rican, etc.)	- 1	14. Race - Ame Black, White		
36	J within 72 hours after death with the Maryland jiele. r than "natural", or Items 23s or 28s-1 ehow the Medical Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 □Yes If Yes, 0 Year or	2 ∕Q No Sive Dates:		1 ☐ Yes	2 \ No	Specify:				Specify:	white	
Maryland 21215-0036	tural E		15. Decedent	s Education		16a. Dece	dent's Ųsu	al Occupa	ation			16b. Kir	nd of Business/	Industry	
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פ	be filed ital Hygid of other	Bec	17. Father's Name (First, Middle, L	ast)					18. Mothe	er's Name	(First, Middle	, Maiden	Surname)		
<u>ya</u>		To.	Robert Wilson		J.						Doroth	_		T. O. 4:1	
Jar	2 she and is m		19a. Informant's Name/Relationsh		a						sup, M		r Town, State, 2 1794	LIP Code)	
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		Robert Hoffman -	- nuspano							sup, ru		cation - City or	Town, State	
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Baltimore,	permit. Pag Department Importent: I any injury o		' 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature, of Funeral Service L		Lar	ke View	2 Name a	nd Addres	ss of Facilit	2/24	1000		esville		
Ba	permit. Departr Importe eny inj		mer H	ackma	4	Ga	ry L.	Kau	fman	Fune	ral Hor	ne at	Meadow	cidge ME 21075	, Inc.
			23a. Pert1. Enter the disease, or	complications tha	t caused the dea	ath. Do not en	ter the mo	de of dyin	g, such as	cardiac c	r respiratory a	rrest,	- IVII.	Approximat Interval Bet	10
	Physician		shock, or heart failure. List of Immediate Cause (Final	only one cause or	each line.	25	dro	0		2	archi			Ones teen	Death
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89 X	leath certificat attending phy I for use as th	/Me	IF FEMALE:		outcome of preg							2	23d. Date of del	ivery	
.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		e birth 2 □ Fe gnant at time of known		□Ectopic p □ Other (s						Month		Year
Δ.	that the deed by the detached	Ph	Part II. Other significant condition	ns contributing to	death but not re	sulting in the I	underlying	cause giv	en in Part I	,	23e. Did	tobacco u	se contribute to	the cause of	death?
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ital		Be C	25. Was case referred to medical examiner?								(Check only				
Ž <	> .00	To	1 Yes 2 No		☐ Inpatient 2				er: 4 🗆 Nu				6 ☐ Other (Spe	cify)	
Division of Vital	Jing Pl J. After th funera		27. Manner of Death 1 Natural 5 □ Pendin	9	te of Injury onth, Day Year)	28b. Time o Injury	of M	28c. Injun Wor	yat k? Yes 2□	1	28d. Describe	how injury	y occurred		
isio	Attending in death.	cat	2 Accident investig	ot be 280 Pla	ce of Injury - At	home farm s			163 20		28f. Location	Street and	d Number or Ri	ural Route Nun	nber,
Di≤	ospitel or Attendi hours after death. Ineral Director: A ly filled in by the fu	Certification:	4 ☐ Homicide determ	ned bui	lding, etc. (Spec	cify)		,,			City or To	wn, State,)		
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	To the within To the or plant	Me	29b. Sign, ture and title of sertifier			_	29	c. Licens	e number			29d. Dat	e signed (Mont	h, Day, Year)	. ,
	6		- 18 Ch	er	> 1	Ch		1) (696	54	of the second		2-2	3-0	4
	11/		30. N me and address of person	who completed ca	ause of death (It	em 23a) (Type	, Print)	^			4	0	0 11 5		
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	St Regist	ate trar	31. Date filed (Month, Day, Y	B 2 4 20	Registrar's sig	nature	y A	head	E)						

		-	Please For State Registrar	State of Ma	aryland / Depa Ce	artment of h rtificate of	Health and N	lental Hygie	ene 2004	05725
٥	Physicia /Medic	an al	Hegistrar Decedent's Name (First, Middle, La Nicholas Nicholas Hegistrar Nicholas Hegistrar	L		lowach	or Location of Death	2. Date of Death Month	Day Year 23, 2004	3. Time of Death 6:00 AMM
	Examin Funeral Director	G I	Millenium Healt 5. Social Security Number 6.	h and Reha	bilitation (In yrs. last birthday) 84 Yrs.	Glen B	urnie	8. Date of Birth (Month Day)	Anne Arun	idel place (State or Foreign CONTA, NY
	ט		Usual Residence of Decedent 10a. State 10b. County NY OTSI	EGO	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the	Funeral Director	10e. Street and Number 5 West Street				820		g. Citizen of What Cou USA 14. Race - Ameri	
9036	be filed within 72 hours after death with the Maryland the Hygiene. And the Hygiene worth. The Medical Examination must be confifted at event, the Medical Examination must be confifted at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 15 Yes 2 1 If Yes, Give Year or Dates	Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2XXNo	Hispanic Origin? (Spean, Mexican, Puerto		Black, White, Specify: Wh	etc. IITE
21215-0	filed within 72 he Hygiene. other then "natu ent, the Medical	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12		(Give life.	dent's Usual Occu e <i>kind of work don</i> e <i>DO NOT us</i> e retire halmolog	during most of work ad)	sing	6b. Kind of Business/Ir Medical	dustry
Maryland 21215-0036	should be filed ind Mental Hygis marked other umetic event, II	To Be C	17. Father's Name (First, Middle, Las Nicholas T. Ho	Lowach	10b Mail	ing Address (Street	Mary Ph		aiden Sumame) City or Town, State, Zi	n Code)
	d 2 th al tre tre		19a. Informant's Name/Relationship Lorraine Holowacl 20a. Method of Disposition X	n - Wife	PO I	Вох 873,	Oneonta,	NY 13820	Oc. Location - City or T	own, State
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		1 Signature of Funeral Price Lice 21. Signature of Funeral Price Lice 1. Signature of Funeral Price	ensee	(48)	2. Name and Address 26 CRAIN	ess of Facility FIN	K FUNERAL	L HOME, PA NIE, MD 210	
760,	Physicien: The law requires that the death certificate be executed This certificate has been signed by the attending physician and This certificate has been signed by the attending physician and This certificate has been signed by the attending physician and This certificate has been signed by the attending physician and a property of the physician and a property of the physician and a property of the physician and a property of the physician and a physi	dical Examiner	23a. Part1. Enter the disease, or conshock, or heart allure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the constant of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of): a consequence of): a consequence of):	Arry Ita Debili Harri	nia lip_			Interval Batween Onset and Death
P.O. Box 68	the death certific y the attending p iched for use as	Physiclan/Medi	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	cy		23d. Date of deliv Month	ery Day Year
	w requires that s been signed b should be deta		Part II. Other significant conditions Democh	contributing to death t	out not resulting in the	underlying cause g	ven in Part I.		acco use contribute to	
al Reco	n: The law re licate has be r, page 2 sh	Completed by					00 Plan 4 Page	 	prior to co death? No 1 \(\sum Yes\)	opsy findings available impletion of cause of
Division of Vital Records,	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be	25. Was case referred to medical examiner? 1	h-	ury 28b. Time ay Year) Injury	of 28c. Inju	ther: 4 Nursing H ury at ork? Yes 2 No	28d. Describe how	nce 6 Other (Speci	
Divi	Hospital or At 24 hours after of Funeral Direct tely filled in by	al Certifi	4 Homicide determine	building, e	jury - At home, farm, s tc. (Specify)			City or Town,		
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 ☐ Medical Exone) 29b. Signature and title of certifier	aminer: On the basis and manner s	of examination and/or i	nvestigation, in my	opinion, death occu	rred at the time, da	te and place, and due	to the cause(s)
	ok'		30. Name and address of person wh	o completed cause of	death (Item 23a) (Type	a, Print) AVF STF	231 ANIN	VAPOLIS	, MD. 21	401
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 4 2		rar's Signature	back				

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Mar Inne /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner more HMORE Rlando tre If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex, 1 M, 2 ☐ F If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Hours Months a Yrs. 4 3-58-372 Vari Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No ALTIMORE ALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 ANDO within 72 hours after death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, item 27 is marked other than "natural", or Items other traumatic avant. In Madical Examinating 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No Baltimore, Maryland 21215-0036 Specify: Specify: Whi þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. omemaker es 1 and 2 should be filed w of Health and Mental Hygier If item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be aureen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2123 4 19a. Informant's Name/Relationship (Type, Print) Rb. TIMO 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 20a. Method of Disposition Pages 1 permit. Pages
Department of H
Important: If ite 1 Burial 2 □ Cremation 3 Removal from State ò PARKWOOD CEMETER 4 □ Donation 5 □ Other (Specify) injury 22. Name and Address of Facility BALTIMURE, MD 21. Signature of Funeral Service Licenses 212 any i CHAPEL, 8800 EVANS FUNERAL 10 23a. Part . Enter the disease or complications that caused the death shock, or heart failure/List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) CANCER BREATT Pnysician METAITHE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner nding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? jo 4□Pregnant at time of death 5 Other (specify) P.O. I detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ρ ate has been signi page 2 should be 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate rector. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Å Residence 6 ☐ Other (Specify, Certification: To 1 🗌 Yes funeral dir 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Seath 1 Z Matural 28c. Injury at Work? 28b. Time of After 5 Pending after death. 1 ☐ Yes 2 ☐ No М investigation ∠ □ Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funerel I

completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the ! 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 104 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAS 656 200 432. Registrar's Signature 31. Date filed (Month, (2) 27) 4 State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 State Registrar AMEND ITEM #21 PER FH G828 2/26/04 Giertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 02 18 2004 2:55 P Joann Hedeman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore 406 Gun Rd. | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 6/1/1950 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2🖺 F 53 Maryland 217-54-2647 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Show ed other than "natural", or items 23e or 28e-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Baltimore MD Baltimore the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with United States 21227 406 Gun Rd. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Atkinson, Sr. Dorothy Swinder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard L. Hedeman / husband 406 Gun Rd. Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ot
once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bayview Crematory * 4 □ Donation 5 □ Other (Specify) 2/20/2004 Baltimore, Maryland 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee CATHERINE N. TOLBERT MO1381 per DVR 1328 Sulphur Spring Rd. Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Finaf disease or condition **Physician** Obstru hronce resulting in death) /Medical Due to (or as a consequence of): **Examiner** for complementence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and ned for use as the burial-transit Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of defivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has certificate 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending Injury To the river after death.

Within 24 hours after death.

To the Funeral Director: Att 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 0 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 518 2004 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1120 N-Rellin Baltinn

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

A

32. Registrar's Signature

		_	For	State of Maryland /			ntal Hygiene	2001. 05720
		1	State Registrar		Certificate o		Reg. No.	3. Time of Death
///	/siciai ledica		1. Decedent's Name (First, Middle, Las	HOPKINS	4b. City Jown	, or Location of Death	Month Day	
EX	amine		BONSQUEE	Horatal	EA	1. timors	0	NIA
Fund Direct		5	5. Social Security Number 239-20-1479 1 Usual Residence of Decedent	PX 7. Age (In yrs. last 83	Yrs. If Under 1 Yes Months Day	ar If Under 24 Hrs. 8	Date of Birth (Month, Day, Year)	South Carolina
death with the Maryland ms 23s or 28e-f show	lat at		10a. State 10b. County	10c. City, To	own or Location 1 himore			10d. Inside City Limits 1 Stres 2 ☐ No
ith the	as notifi	Funeral Director	10e. Street and Number	, ,	10f. Zip Code		10g. Cit	zen of What Country?
eath w	Tuest	era	3432 Colmo	12. Was Decedent Ever in U.S.	2 2 2	of Histanic Origin? (Speci	fy Yes or No-	14. Race - American Indian,
i je	examiner	2	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give (Year or Dates:	If Yes, specify C	uban, Mexican, Puerto Ri	can, etc.)	Black, White, etc. Specify: Black
215-0036 thin 72 hours af e. an "natural", or	odical	Completed	15. Decedent's Ed (Specify only highest gra		6a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use ret	ne during most of working	/ 16b. Ki	nd of Business/Industry
2121 od within gjene.	It e M	E C	Elementary/Secondary (0-12)	College (1-4or 5+)	Shop.	steward	D.	rydock
and 2 d be filed antal Hygi	c event,	o pe c	17. Father's Name (First, Middle, Last)	kin s	/	18. Mother's Name (First, Middle, Maiden	Sufname)
Maryland d 2 should be fill th and Mental H T is marked out	traumati	-	19a. Informant's Name/Relationship	pe, Print) 1	9b. Mailing Address (Stre	eet and Number or Rural i	Route Number, City o	r Town, State, Zip Code) 21229
or Healt	r other	-	20a. Method of Disposition	come	o of Disposition (Name of etery, crematory or other p	Dad Sen o	te 20c. Lo	ocation - City or Town, State
Pag ment ent: 1	injury or	r	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Lices)	v) Ore	en mount Con	notory Feb	2004 Ba	Ho hd.
Balt permit. Departi	any ii		Call for C.	Douglan	Car for	c Cull sh	t. Ball	6. led. 21227
760, /Med Example Exam	iner	EXa	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequent		vtenor My Arkery	aradial 18 DEPA	Interval Between Onset and During
Box 687 sath certificate attending phys	0	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes No 9 □ Unknown	_d	ath 3 ☐ Ectopic pregna			23d. Date of delivery Month Day Year
ds, P.O uires that the signed by th	p eq .	2	Part II. Other significant conditions	contributing to death but not results	whithe underlying cause	given in Part I.	23e. Did tobacco to	ise contribute to the cause of death?
Vital Records, sician: The law requires to certificate has been signe	ge 2 should	Completed					24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	. page						performed? 12 Yes 2 □ No	death? 1 Yes 2 No
	5	o Be	25. Was case referred to medical examiner? 1 ☐ Yes — 2 ☒ No	Hospital: 1 Inpatient 2 ☐ ER	/Outpatient 3 DOA	26. Place of Death (Other: 4 ☐ Nursing Home	Check only one) 5 ☐ Residence	6 □Other (Specify)
Jing Afte	funeral	ation: T	27. Manner of Death 1 A latural 5 Pending 2 Accident investigatio	28a. Date of Injury 28 (Month, Day Year)	Injury V		d. Describe how initur	
Division Hospitel or Attending 44 hours after death. Funeral Director: After	d in by th	Certification:	3 Suicide 6 Could not be determined		, farm, street, factory, office	Ce 28	f. Location (Street an City or Town, State	d Number or Rural Route Number,)
Divisic To the Hospitel or Attent within 24 hours after death To the Funeral Director:	etely fille	Medical C	29a. Certifier Certifying Ph	nysician: To the best of my knowle miner: On the basis of examination and manner stated.	dge, death occurred at the and/or investigation, in m	e time, date and place, an ey opinion, death occurred	d due to the cause(s) I at the time, date and	and manner as stated. place, and due to the cause(s)
To the I	compl	Me	29b. Signalure and title of certifier	Do DO	29c. Lice	ense number	29d. Dat	e signed (Month, Day, Year)
1		-	30. Name and address of person who	completed dause of death (Item 2	Pa) (Type, Print)	2+165	1 2	10/2004
9			H. New Raynolds	BON SQUUST	Hospital, 2	2000 Wast	Baltimor	o Stroot
Re	Stat egistra		31. Date filed (Month, Day, Year) FEB 2	32. Register's Signature	of Locale)		·

State of Maryland / Department of Health and Mental Hygiene 2004 05729 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 18, **Physician** 2004 9:10P Harris Robert Palmer /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Darlington Harford Country View Assisted Living If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 18, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 1**X** M 2 □ F Yrs. Maryland 220-20-4198 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 te marked other than "natural", or items 23a or 28a-f ahow ary or other traumatic avent, the Medical Estimator Author Author Author Called at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1X Yes 2 □ No Baltimore Director Maruland N/A10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number u. s. A. 21239 1910 Northbourne Rd. Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 Yes 2 No Black 3 ☐ Widowed 4 ₺ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Federal Aviation College (1-4or 5+) Elementary/Secondary (0-12) Radar Technician Administration Years 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Mary Woodhouse Columbus Harris 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1910 Northbourne Rd., Baltimore, Md. 21239 Melanie Harris (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. 2/21/2004 Baltimore Maruland Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 3331 Brehms Lane, Baltimore, Md. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stag **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and burial-tran Due to (or as a consequence of) Box 68760. the attending physician Physiclan/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, should be 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 DNo ted Deen 24b. Were autopsy findings available prior to completion of cause of death? Complet 24a. Was an autopsy performed? (es 2 No page 2 2□ No 1 Yes 1 TYes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 ther (Specify) Susted Hospital: 1 ☐ Inpatient 2 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Lirector: A 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 15. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number f erson who completed cause of death Item 23a) (Pipe, Print) PERRY POINT HURNANDG AFLWA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Physician 403PM tilms February 18 Ethel 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOUNTROOM bospital Center Randallshown Baltimore If Under 1 Year If Under 24 Hrs. Nonths Days Hours Min. Day, Year)

Dec. 13, 1930 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1 □ M 2 □ 214264 656 Director Maryland Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County Items 23a or 28a-f ehow the Medical Examiner must be notified at Maryland 1√ Yes 2 No N/A Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3464 - 6th Street 21225 U.S. Completed by Funeral Peges 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
snt: If item 27 le marked other then "natural", or Items 23sury or other traumatic event, the Medical Examinar must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2√€ No Specify Specify: White 3 ☐ Widowed 4 ♣ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Goulds Electronics Wired Service Boards 12th 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Alexander Sosnowski Virginia Jenkins ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Gentry 1200 Battery Avenue Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Pege Department of Important: If eny Injury or 2/19/2004 Baltimore, Maryland Bayview Crematory ⁴ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee nomicall 4001 Ritchie Highway Baltimore, Maryland 21225 23a Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pulmonar **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner ASCVD Sequentially list conditions, Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or injury sicion and burial-transit or Attending Physician: The law requires that the death certificate be executed achieardia Venoricilar that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. ser Kale Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a 9 Unknown s been signed by the should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 212 No page this certificate 1 ☐ Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 은 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death.

To the Funerel Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital i'Destritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0658141 February 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) old court Road Randallshown, MD 21133 Williams 5401 Wundie 39. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar FEB 2 4 2004

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Feb. 19, 2004 9:30 Hon. Judge A. Owen Hennegan, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1921 Maryland 82 Director 213-12-8682 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County is 1 and 2 shows 2...
if Health and Mental Hygiene.
item 27 is marked other then "natural", or items 23a or 28a-f show
item 27 is marked other then "natural", or items 23a or 28a-f show
item 27 is marked other then "natural", or items 23a or 28a-f show 1 ☐ Yes 2 🔀 No Director Md. Timonium Baltimore 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21093 USA 12261 Roundwood Road Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☑Yes 2□No WWII, If Yes, Give Year or Dates: Korea 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specity: Specify 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Baltimore 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore College (1-4or 5+) Elementary/Secondary (0-12) 5+ County Circuit Court Judge 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be f nd Mental Marie Veronica Schilpp August Owen Hennegan, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hon. Judge John O. Hennegan/Son 5 Whitewood Court Baltimore, Maryland 21236

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō = 6 rtment rtant: I njury c Dulaney Valley Mem. Grd. 2/23/04 Timonium, Maryland 22. Name and Address of Facility permit.
Deporte
Importe
any nju 21. Signature of Funeral Service Licensele Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stroke - hemorrhagic week **Physician** /Medical Due to (or as a consequence of): **Examiner** 200 melanoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician ar s the burial-t Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear Day in the past 12 months? ō 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ tibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed congestive heart failure 24a. Was an autopsy performed? 1 ☐ Yes 2 🔼 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Jas certificate ha 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Diractor: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 □·Homicide within 24 hours a To the Funeral C 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 1725205 cey, no 30. Name and address of person who control ted cause of death (17 m 23a) (Type, Print) Charles St. Rollo. md 2120x GBMC 6701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 2 4 2004

State of Maryland / Department of Health and Mental Hygiene 2004 05732 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Adele Dunigan Harrington EBRUARY 19,2004 /Medical 6:45 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 10-24-1919 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🖸 F 134-18-2240 84 Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 28a-f show 10d. Inside City Limits and be nutilized at Anne Arundel 1 ☐ Yes 2X No Director Linthicum 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 or Herns 23a 6208 Orchard Road 21090 death \ USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. The Mudical Expression C filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other treumatic event, the Mustic 2005. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Dunigan Olga Ladley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Mary Harrington/daughter 1547 Hollingsworth Rd., Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial | 2/23/2004 * 4 □ Donation 5 □ Other (Specify) Elkridge, MD 22. Name and Address of Facility Singleton Funeral Home 21. Signature of Funeral Service Ligensee mna Dallas M01364 1 Second Ave SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIO RESPIRATORY ARREST /Medical Due to (or as a consequence of) **Examiner** MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit CORONARY ARTERY DISEASE and Due to (or as a consequence of): allending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month 4☐Pregnant at time of death Day Year 5 Other (specify) ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? VENTRICULAR ARRYTHMIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No LACTIC ACIDOSIS autopsy performed 1 Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 5 Pending 1.XNatural Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral L 15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11 chard - withicking 2-19-04 D 31826 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD INTHICUM M. D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrat's Signature State FEB 2 4 2004 >

DHMH 17 Rev 1/200

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 18,2004 10:50 A Cynthia James /Medical 4c. County of Death
PREDERICK 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 400 W. 7Th 91 HOSP treperick memorise Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Days Hours 1 □ M 2 X F 242-90-5662 SEPT 24, 1956 Director New York Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ral', or Itams 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Clarksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14406 Lewisdale Road 20871 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed of Health and Mental Hygiene.

Itam 27 is marked other than "natur
other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Telephone Industry Computer Operator 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Allen Sanderson Sarah Faile 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clarksbur, MD Michael Allen James/Husband 14406 Lewisdale Road 20871 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Other (Specify) 2-21-04 4 Donation Metro Crematory Inc. Baltimore, MD ²² Name and Address of Facility Cremation Society of MD 299 Frederick Road Ba 21. Signature of Huners Dawn F. McDonald Inc. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ASH! Immediate Cause (Final disease or condition resulting in death) robablo ME **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease o. injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed detached for use as the burial-transit Due to (or as a consequence of): physician Box 68760 Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ۵ 1 Yes 2 No 3 Probably 4 Unknown is certificate has been si director, page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 □ Yes 2 No this 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: filled in by the Could not be 28e. Place of friury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completely filled in by determined 4 \(\text{Homicide} \) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier w eath (Item 23a) (Type, Print) ER 4 200 432. Registraris Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 9:07A Christine Jones February 18,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Oct 12] 9. Birthplace (State or Foreign Country)
TN **Funeral** Days Hours 1 ☐ M 27 F Yrs. 220-72-7414 Director Usual Residence of Decedent iiled within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f show any njury or other traumatic event, Ita Madical Examinating traumatic avent, Ita Madical Examinating Percolling an once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Carroll Mt. Airy 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 4101 Baltimore National Pike USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give \(\Lambda \). Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Grover Jones (spouse) 4101 Baltimore National Pike, Mt. Airy, Md 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Sharon Baptist Cem. West Friendship, Md 2-20-04 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, Md 21784 suan or. 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Aspiration Preumoneg resulting in death) /Medical Due to (*r as a consequence of): **Examiner** leura us con Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence f) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy detached for Month Day Year 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by a page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43091 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Horse Are, Frederick MI SAEED 801 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FFB 2 4 2004 Registrar

	Physici		1 - For AMEND Item://23e Registrar 1. Decedent's Name (First, Middle, Las					Death	2. Date of D Month FEB			3. Time of Death 5:55a M
7	/Medic Examir		4a. Facility Name (If not institution, give 2150 Troon Over1c	street and number)			4b. City, Town, or	Location of Dea			County of Dee Howard	th
	Funeral Director		5. Social Security Number 6. Se 11 11 11 11 11 11 11 11 11 11 11 11 11		(In yrs. last birth 74 Yı	rs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth ay, Year 192	9. Bir	thplace (State or Foreign country) Cyland
	aryland show	1	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the Ma la or 28a-f	Director	Maryland Baltime 10e. Street and Number 2150 Troon Over		20 °7 Sec.	Wo	odstock 10f. Zip Code 211	L63		10g. Ci	itizen of What Co	
936	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic svent, its Medical Examinat must be redified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Agned Forces? 1 (2) Yes 2 N If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba		Specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, Whi	
21215-0036	l within 72 hou iene. r then "natura I're Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de com <i>pleted)</i> College (1-4or 5	+)	Give ki life. Di	nt's Usual Occupind of work done of NOT use retired	during most of wo			Kind of Business	Andustry
Maryland 2	S should be filed withing and Mental Hygiene. Is marked other than surnatic svent, I. a. M.	To Be C	17. Father's Name (First, Middle, Last) Christopher Kron	, Sr.					me (First, Middle Stephani		-	er
	1 and 2 sho Health and Iem 27 is my		19a. Informant's Name/Relationship (7 Patricia Feeley H				Address (Street a				or Town, State, . ock , MD	
Baltimore,	0 0		20a. Method of Disposition 1 Burial 24 Cremation 3 4 Donation 5 Other (Specify		i		tion (Name of atory or other place natory.]	1	Date	20c. L	ocation - City or	Town, Stete
Balti	permit. Peg Department important: I any injury o once.		21. Signature of Huneral Service Incention of Property Pr		del	22.	Name and Address	ss of Facility			Ltimore, Inc. MD 212	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or companies, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Conge Due to for as a	e. Stile a consequence of	Hei	the mode of dying		c or respiratory a	arrest,		Approximate Interval Between Onset and Death
68760,	ficate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to infiniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	r consequence of							
		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		ctopic pregnancy Other (specify)				23d. Date of de Month	ivery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions co	entributing to death bu	it not resulting in t	the und	lerlying cause give	en in Part I.		,		the cause of death?
al Records,	ician: The law requ certificate has been rector, page 2 shoul	Completed							24a. Was auto perfe 1 Yes		prior to	utopsy findings available completion of cause of 2 No
ion of Vital	ding Phys h. After this funeral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day	nt 2 ER/Outp y Year) 28b. Tin		28c. Injury Work	er: 4 🗆 Nursing F	ath (Check only Home 5X Res 28d. Describe	idence		cify)
Division	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ry - At home, farn . <i>(Specify)</i>	n, stree	it, factory, office		28f. Location (City or To			ural Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edicai	29a. Certifier (Check only one) 2 Medical Exem	vsician: To the best of iner: On the basis of and manner sta	examination and/	death o	occurred at the time stigation, in my or	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s date and) and manner as d place, and due	stated. to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	setters.	MD		29c. License				te signed (Mont	
	20		30. Name and address of person who of	completed cause of de	path (Item 23a) (T	ype, P	rint)	51	Baltin	0-0,	MA	21201
0	Sta Registi		31. Date filed (Month, Bay & edi) 20	4 32 Aegistra	r's Signature	A.	M.	-				

			Tor State Registrar	State of Maryland / I	Department of H Certificate of I	lealth and Me Death	ntal Hygien Reg. N	°2004	05736
			1. Decedent's Name (First, Middle, Last)			2.	Date of Death Month D	ay Year	3. Time of Death
	Physicia /Medic		Estella K. Ki	rby				7 04	1:39 PM
	Examin		4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or	Location of Death	4	c. County of Death	
			Franklin Squa	1e 1705011a1	ROSe	dale		Baltir	nde
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit	Months Days	Hours Min.	Date of Birth (Month, Day, Year	r) Cour	lace (State or Foreign try)
	Director		213-20-0434	M 21XF 75	Yrs.	I I	ec. 3,19	28 Mary	Land
	pue *	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or Location			1	0d. Inside City Limits
	f sho	ō	Maryland Baltimor		Baltimo	ho			1 ☐ Yes 2 👿 No
	28a-	Director	10e. Street and Number	e	10f. Zip Code		10g. C	itizen of What Cour	ntry?
	with Sa or		3304 Iris Lane		21	220		u.s.A.	
	Jeath	Funeral		2. Was Decedent Ever in U.S.	13. Was Decedent of H		y Yes or No-	14. Race - Americ	
(0	ritar	교	1 ☐ Never Married 2 💢 Married	Amed Forces? 1 ☐ Yes 2 X No			can, etc.)	Black, White,	
8	eal', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Yes 2 ▼ No	Specify:		Specify: (W)	rite
ည	within 72 hours after death with the Maryland ene. than "neturel", or Itams 23a or 28a-f show fra Majical Examirer must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		Decedent's Usual Occup (Give kind of work done of	ation during most of working	16b.	Kind of Business/Ind	dustry
7	thin e	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	1)			
2	filed w Hygier other th	Š	10th Grade		Homemaker	40. 14-15-1-11		own Home	
Maryland 21215-0036	ed at be	Be	17. Father's Name (First, Middle, Last) Robert Melvin K	alam Th		18. Mother's Name (F			
₹ Z	should be ind Mental Is marked o	၉				Mildred	May Mye		Code)
<u>Jar</u>	12 sh and r is m		19a. Informant's Name/Relationship (Type Mr. Lawrence R. K		D. Mailing Address (Street .				Code)
	ges 1 and 2 should t of Health and Men If itam 27 is marks or other traumatic		20a. Method of Disposition		3304 Tris La of Disposition (Name of	ne, buttuni		27220 Location - City or To	own. State
Baltimore,	nt of h		1 🔀 Burial 2 □ Cremation 3 🗀 Re	moval from State	ry, crematory or other plac	(e)			
Ë	rtmer rtant rtant njury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service License		Chapel UMC C	1		rry Hall,	
Ba	permit. Pages Department of It Important: If its any injury or of		21. Signature of Figure 21. September 21. Se		9705 Bela	^{ss of Facility} Schü ir Rd., Ba	muner Fun ltimore,	ieral Home MD 21236	
			23a. Parti. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. Do					Approximate Interval Between
	Physician		Immediate Cause (Final	Musocali	al In	fareti			Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence	of):				····
	Examiner		Sequentially list conditions b						
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Userful Cause (Disease or injury	Due to (or as a consequence	of):				
	cuted nd ransi	Examiner	that initiated events						
ó,	e exe ian a urial-1		resulting in death) Last	Due to (or as a consequence	of):				
8760,	death certificate be executed e attending physician and of for use as the bunal-transit	dlcal	d						
9	artific ing p	Mec	IF FEMALE:						
Вох	ath certific attending p for use as	an/	23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death		,		23d. Date of delive Month	Day Year
0	se de the a	Physician/Me	1 ☐ Yes ♠ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)				
σ.	that the ed by th detach		Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause giv	en in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
ds,	signe d be	d by			, , ,		1 ☐ Yes	2 No 3 ☐ Prob	ably 4 DUnknown
Vital Record	w requ been shoul	Completed					24a. Was an	24b. Were auto	psy findings available
Re	The taw ate has b page 2 st	Ĕ					autopsy performed?	death?	mpletion of cause of
æ	an: Th tificate tor, pag		25. Was case referred to medical			26. Place of Death (6	Check only one)	lo 1□Yes	2L1 N0
₹	Physician: this certific ral director,	To Be		ospital: Inpatient 2 ER/O	utpatient 3 DOA Oth	or		6 ☐Other (Specifi	v)
o			27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injur	y at 280	d. Describe how inj		,,
<u>o</u>	Attanding I or death. ector: After by the funer	at lo	Natural 5 Pending investigation	(Month, Day Fear)	Injury Wor M 1	Yes 2 □ No			
Division	Attandii er death. ector: A by the fu	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28	f. Location (Street a City or Town, Sta	and Number or Rura te)	I Route Number,
ā	s afte	Certification;							
	To the Hospital or Attanowithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier Certifying Physical Check only one)	ician: To the best of my knowledg ler: On the basis of examination a and manner stated.	e, death occurred at the tir nd/or investigation, in my o	me, date and place, and pinion, death occurred	d due to the cause(at the time, date a	s) and manner as sind place, and due to	tated. the cause(s)
	o tha ithin (o tha omple	Mec	29b. Signature and title of certifier	site manufactured.	29c. Licens	e number	29d. D	ate signed (Month,	Day, Year)
			> M (1)	011	D51	0979	2	20/20	04
	3		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print)		~	100	21061
		-	Madai Chard	D ZYSF No	a twood	RD Stel	DD Gle	n Burns	e, MD
	Sta Regist		31. Date filed (Month, Day, FEB 2	32. Registrar Signature	1 Louis				

Amend 1tem 22 per dvr 9855 5-23-06 vt.
State of Maryland / Department of Health and Mental Hygiene 200 Lestrar

State of Maryland / Department of Death

Certificate of Death

Reg. No.

			For State Registrar 1. Decedent's Name (First, Middle, Las		aryland / i	Cer	tificate of	Death	2. Date of Deat	eg. No.	2004	05737
Н	Physici		EUGENE	KEMP'	riro				Month FEBRUARY	Day 18	Year 2004	11:45 A M
>	/Medic Examir		4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of Deat			ounty of Death	111.45 11
н	Exami	e.	MARINER HEALTI				FORE	ST HILL			HARFORD	
	Funeral		5. Social Security Number 6. Se	7. Ag	je (In yrs. last bi	rthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		YearL .	9. Birthp	place (State or Foreign
	Director		215-10-8534	XM 2□F	89	Yrs.	Working Days	110010	July 26,	, 191	4 Mary	Tand
	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation				1	0d. Inside City Limits
	sho	5	Md. Harford		-	e1 A						1 ☐ Yes 2 ☐ No
	the N	Director	10e. Street and Number				10f. Zip Code		1	0a. Citize	en of What Cour	ntry?
	with Ba or		211 Princeton Lan	e				21014		Uni	ited Sta	ates
	leath	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Was Decedent of I	Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14	I. Raca - Americ	
ထ	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Madical Examiner Lust be muilfied at		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give			1 Yes, specify Cub 1 □ Yes 2 🖾 No		to Hican, etc.)		Black, White, Specify: Wi	™ite
ğ	ral', c	l by	3 ⅓Widowed 4 ☐ Divorced	Year or Dates:			1 195 2 2 2 140	Specify.			pecny.	
ις.	72 h	Completed	15. Decedent's Ed (Specify only highest gra		16a	. Deced	lent's Usual Occu kind of work done	pation during most of wo	rking	16b. Kind	d of Business/In	dustry
Maryland 21215-0036	Mithin ne. than	E E	Elementary/Secondary (0-12)	College (1-4or	5+) †		and die			manı	ıfactur	ing
N B	Hygie Hygie ther i		12 years 17. Father's Name (First, Middle, Last)			001	and are	,	me (First, Middle, I			
au	d ba	To Be	Albert Kempter					Eva Ma	yberger			
<u> </u>	Shoul nd Me mark	F	19a Informant's Name/Relationship (ype, Print)	19	o. Mailir	ng Address (Street	t and Number or R	ural Route Number	City or	Town, State, Zip	Code)
Š	nd 2 alth a 27 is r trav		Eleanore L. Shank	sister- s/1 _{aw}	in- 20	7 P	rinceton	Lane, Be	1 Air, Mo	d. 2	1014	
re,	item item othe		20a. Method of Disposition		cemete	of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Loca	ation - City or To	own, State
Ë	Paga nent c int: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Hemoval from State)	More1	and	Memoria	1 Pk. 2/2	21/04	Balt:	imore, 1	4d.
Baltimore,	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Examiner could be notified at once.		21. Signature of Funeral Service Licen	S00	1	22	Name and Addr	ess of Facility	Home of	R _o 1	Air T	ne
<u> </u>	205 29		1 Cl	W			510 W. M	acPhail R	d. Bel A	ir.	Md. 210	14
7			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	one cause on each i	ine.					est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. & 5	18	tee	a de	ulu	,			
B	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):						
ġ		<u>-</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as	a consequence	of):						
	insit	듵	cause. Enter Underlying Cause (Disease or injury that initiated events								-	
Ć.	law raquiras that the death certificate be exacuted as baen signad by the attending physician and 2 should be detached for use as the burial-transit	Examiner	resulting in death) Last	Due to (or as	a consequence	of):					-	
68760,	rsicia e bur	edicai		d								
	tifical ng phy as th		15551115									
Вох	th cer tendii r use	Physician/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Petal deat	n 3[Ectopic pregnanc	су		23	d. Date of deliver	ery Day Year
	e dea he at	sici	in the past 12 months? 1 Yes 2 No	4□Pregnant a 9□Unknown	it time of death	5	Other (specify)				INIOTHI	ou, roc
P.0	d by t	Phy	9 ☐ Unknown Part II. Other significant conditions of	notributing to death l	but not resulting	in the u	nderhing cause a	van in Part I	23e Did to	hacco us	e contribute to t	he cause of death?
JS,	iras ti signa i be d	by	1	aler	de la	111110 0	ridariyirig badaa gi	TOTAL CALL		es 2 🗆		
Record	raqu	Completed by	- Journal of Control o	7								
3ec	a lav	ig m							24a. Was a autops perfori	sy	prior to co death?	psy findings available mpletion of cause of
	Th ate pag								1 Yes	2 No	1 🗆 Yes	2 No
Vital		Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/O	utnation	nt 3 DOA Ot	hor x	ath (Check only on		Cother (Specie	-
οţ	Phys r this aral di	: To	27 Manner of Death	1 ☐ Inpati	ury 28b.	Time o	f 28c. Inju	ary at	Home 5 Reside			y)
O	Attending or death. ector: After by the fune	tio	1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year)	Injury		ork?]Yes 2∐No				
Division	l or Attendi after death. Director: A in by the fu	ifice	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	200. Flace Ul III	jury - At home, f	arm, sti	eet, factory, office		28f. Location (Si City or Town	treet and	Number or Rura	al Route Number,
Ö	tal or A	Certification:		Danding, 4					1, 5			
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical		ysician: To the best niner: On the basis of and manner s	of examination a							
	To the within 2. To the complet	Me	29b. Signature and title of certifier				29c. Licen	se number			signed (Month,	
)	_		David 5):			2) 3	12299		Fele	runna	19,2001
	6		30. Name and address of person who	completed cause of	death (Item 23a	(Туре,		,	0 /			

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 200405738 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Enola H. Kelso 15, February /Medical 2004 3:01 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Cumberland Memorial Hospital Allegany 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Sept. 29, 1918 Pennsylvania If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1□M 2XF 204-03-8341 85 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits worle ral', or Itams 23e or 28a-f ehov Examiner must be notified at 1. Yes 2 □ No Director Maruland N/A Baltimore the 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21205 1034 Iris Avenue Funeral u. s. A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 X Widowed 4 □ Divorced White "natural', and Mental Hygiene.
Is marked other than "naturaumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward High Maru Schwartz 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I other tra Mrs. Mary L. Burow (Daughter) 732 Miller Road, Grantsville, Md. 21536 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Ξ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Gardens of Faith 2/19/2004 Baltimore, Maryland * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses 3331 Brehms Lane, Baltimore, Maryland 21213 233 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preummi Physician days resulting in death) /Medical Due to (or as a consequence of) **Examiner** dau Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner COPD The law requires that the death certificate be executed physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Auti wee Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 21 Yo
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the al 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 4 Unknown 1 Yes 2 No 3 Probably been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has blirector, page 2 s autopsy 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1 🗌 Yes 21 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident 2 🗌 No 1 Tyes after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel I

completely filled pelli Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060476 2004 February ess of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue, suite 102 Dr, Ahmad, Johnson Heights Medical Building, Cumberland, MD 31. Date filed (Month, Day, Year) FEB 2 4 2004 2. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death KNIGHT Day **Physician** MYRON FEBRUARY 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 7. Age (In yrs. last birthday) | HUnder 1 Year | Hunder 24 Hrs. | Months | Days | Hours | Min. 10HNS HOPKINS HOSPITAL 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F 218-76-7729 44 Maryland Director Jan 13, 1960 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at NIA 1 X Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 or itams 23a wharton Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced "naturel" 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) Shipyard Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ERNEST Lee KnigHT Helena Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2234 Entaw Place Baltimore MV 21217 Sandia Williams Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Deportment of Important: If any injury of once. Feb 21, 2004 Bay View Crematory 22. Name and Address of Facility
Remaid H. Gett Son Funeral Home
108 W. With ave. Balli. M. 21. Signature of Funeral Service Licensee Renald a Brayen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DAYS a SEPSIS WITH MULTI-ORGAN FAILURE /Medical Due to (or as a consequence of): **Examiner** D e to (or as a consequence of): IN MILLEY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed be should be detailed Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2X No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown FULMINANT HEPATITIS, ACUTE RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? DISSEMINATED INTRAVASCULAR COAGULATION s certificate has b lirector, page 2 s autopsy pertormen? Yes 20 No A PATITIS C. A 25. Was case referred to edical examiner? 1 ☐ Yes 2 ☐ No ANEMIA OF CHRONIC DISEASE or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MD FEBRUARY 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bekermen NORTH 600 BALTIMORE MARYLAND 21287 JUSTIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB24 2004 Registrar

			1 - State Registrar	State of Mary	land / Depa <i>Ce</i>	artment of rtificate o	f Health of Deati	and M h	tental Hy	giene	004	05741
		1.	1. Decedent's Name (First, Middle, Las	()					2. Date of De	aath Day	Year	3. Time of Death
	Physici /Medic		Dayalaxmi	Khatri					Februa		2004	7:10p M
	Examin		4a. Facility Name (If not institution, give 140 Chevy Chase S			4b. City, Town	n, or Location hersbu			4c. Co	unty of Death gomery	
	Funeral Director		578-74-1652	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Bir (Month, Da Oct. 29	v. Year)	Cou	place (State or Foreign ntry) h Africa
	and		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ecation						10d. Inside City Limits
	Maryi	ţo	Md Montgom	erv	Silver	Spring						1⊠Yes 2□No
	r 28a	Director	10e. Street and Number		522.02	10f. Zip Cod	le		I	10g. Citizen	of What Cou	ntry?
	th with		1119 Orchard Way			2090	4			U.S.	. A.	
	r dea	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent	of Hispanic C Juban, Mexic	rigin? (Span, Puerto	ecify Yes or No Rican, etc.)		Race - America	
36	hours after death with the Maryland turel', or flems 23a or 28a-f show at Exacting frout be notified at	by Ft	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 2 No If Yes, Give Year <i>o</i> r Dates:		1 ☐ Yes 2 🔯 I	No Specif	y:		Spe	ecify:	T 1.
8	"natural",		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Oc	cupation			16b. Kind o	AS 18 of Business/In	an Indian
215	造しまる	piet	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work do DO NOT use re	ne durina ma	ost of work	ing			,
21	× e +	Completed	3rd		Ног	nemaker					ed Home	2
pul	d fa b	Be	17. Father's Name (First, Middle, Last) Naran Jairam						e (First, Middle		name)	
Z ≥	D 9 2 0	2	19a. Informant's Name/Relationship (7	irna Print)	10b Maili	ng Address (Str	Hi:		Unavail		Ctata Zi	Codel
Maryland 21215-0036	" = = -		Hiralal Kharti/S								-0.2 AZ-27070	63
ē,	s 1 ar f Hea ltem other		20a. Method of Disposition	20	b. Place of Dispo	Orchard sition (Name of matory or other)			er Spri		1d 2090 ion - City or To	
Ę	Page nent o int: If		1 ☐ Burial 2 🖾 Cremation 3 ☐ * 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Ba	ıltWash			02-21	-04	Laure	≥1, Md	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It any injury or other tra ance.		21. Signature of Funeral Service Licen.	500		. Name and Ad				ral Ho	ome,Inc	
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of				dying, such a	s cardiac d	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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90,	oe exe		resulting in death) Last	Due to (or as a cor	rsequence of);							
8760,	ate hy:	dical		d								
9 x	eath certific attending p	0 1	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr	egnancy					234	Date of delive	20/
Вох	death a atter d for u	lciar	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		Ectopic pregna Other (specify)		_			Month	Day Year
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al F									1 ☐ Yes	rmed? 2 No	death?	2□ No
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o		\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Yea		28c. ir	njury at		me 5 ☐ Resi 28d. Describe			residence
ion	Attending I r death. octor: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation		(r) Injury		Work? □Yes 2□]No				
Division	N or Attend after death Director: \	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sa	At home, farm, str	eet, factory, office	ce		28f. Location (: City or To		imber or Rura	l Route Number,
	Hospital of hours at Funeral D		On Continue Manager and Continue Manager	A de la constant de l						-M-122.773	-702	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Sertifying Phy (Check only 2 Medical Exam	rsician: To the best of my iner: On the basis of examination and manner stated.	r knowledge, death mination and/or in	occurred at the vestigation, in m	e time, date a iy opinion, de	ind place, i ath occurr	and due to the ed at the time,	cause(s) and date and plac	manner as st ce, and due to	tated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier			29c. Lice	ense number			29d. Date sig	gned (Month,	Day, Year)
	,/		S	KAngra		0	36°	980	P	2_	120	04
	D		30. Name and address of person who					-		T00	· .	
			Satish Angra, M.D. 31. Date filed (Month, Day, Year)	344 Univer		d. West	Sil	ver S	Spring,	Md 20	901	
	Sta Registr		51. Date med (Month, Day, 70a)	Jan Jan	B D	parks	/					

DHMH 17 Rev 1/2001

FEB 2 4 COUNTY

State of Maryland / Department of Health and Mental Hygiene ?

05742 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1:48 P M February 19,2004 Henry William Kowalevicz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1730 Manor Road Baltimore Dundalk Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1√2 M 2 □ F 212-44-2015 Director 56 16,1947 Maryland Aug. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ahow of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Iteme 23s or 28s-1 show other traumatic event, the Micdical Examiner must be nutitled at 1 ☐ Yes 2X No Director Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1730 Manor Road 21222 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? ty⊡Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 25 Married Baltimore, Maryland 21215-0036 þ 1 Yes 2 KNo Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Groundskeeper Schools permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygic Important: If Item 27 Is marked any injury or other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Kowalevicz Evelyn Boddice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Debra Kowalevicz/Wife 1730 Manor Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery 2/23/2004 Rosedale, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart plure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 1010510 MCalke **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that inhiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760 the attending physician IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ğ in the past 12 months? Day 5 Other (specify) P.O. I No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, pe Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? res 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner2 26. Place of Death Check only one Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 10 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 1 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) I in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled To the Hospital Medical 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name Sler Dr Silir E 5110 101 31. Date filed (Month, Day, Year) 32. Regulrar's Signature

DHMH 17 Rev 1/2001

Registrar

20

FEBRUARY

KATHERINE

KACHELE,

within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only 2 Medical Example) 29b. Signal and title of certifier	ysician: To the best of my kn niner: On the basis of examin- and manner stated.	owledge, death ation and/or inve	occurred at the time estigation, in my opin 29c. License in OCME	, date and place, nion, death occurr	and due to the cause ed at the time, date a	e(s) and manna and place, and Date signed (A	er as stated. due to the cause(s) Month, Day, Year) 19, 2004
Jeath. tor: After the fune	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Natural 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 2719704	28b. Time of Injury Unknown nome, farm, streamy)	28c. Injury a Work?	at Page 1 No	28d. Describe how in Unknown	and Number (ate) 302	(Specify) Ar Bural Route Number High Rock Ct
certifica rector, p	o Be Completed	25. Was case referred to medical examiner?	Hospital:	7500	Othor		24a. Was an autopsy performed 1 (2 Yes 2 1 (Chech only one)	? dea	Yes 2□ No
ite has been signed by the	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the un	derlying cause giver	n in Part I.	23e. Did tobacc		ute to the cause of death?
e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🔲	Ectopic pregnancy Other (specify)			23d. Date of Month	,
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hysician /Medical xaminer		23a. Part 1. Enter the disease, or shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. a. Narcotic in Due to (or as a conse	toxicat	r the mode of dying	, such as cardiac	or respiratory arrest,	ore, Ma	Approximate Interval Between Onset and Death
Department of the importent: If its any injury or of once.		* 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lie		22.		of Facility Hul	obard Fune	eral Ho	
fealth a mm 27 is		Sandy Brady / Mo 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Other 20b.	302 H. Place of Dispos cemetery, crem	igh Rock attion (Name of latory or other place	Court, B	rooklyn Pa	ark, Ma	eryland 21225 ity or Town, State
d a b	To Be	17. Father's Name (First, Middle, Last Austin Brady 19a. Informant's Name/Relationship (19b Mailin		Sai	e (First, Middle, Mai ndy Keller ral Route Number, C		
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7. rous allei death with the maryland "netural", or items 23e or 28e-f show olical Exeminer must be political at	d by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	11	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 No	Specify:	pecify Yes or No- p Rican, etc.)		- American Indian, White, etc. White
23a or 28a	rai Director	10e. Street and Number 302 High Rock Cou		DIOON	10f. Zip Code 21225		10g	. Citizen of Wh	nat Country?
Maryland -f show find at	tor	10a. State 10b. County Maryland Anne Aru		City, Town or Loc	lyn Park				10d. Inside City Limi 1 ☐ Yes 2X
Funeral Director			TYM 2DE	s. last birthday) 27 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		9. Birthplace (State or Forei Country) Maryland
Exami	ner	4a. Facility Name (If not institution, given 302 High Rock Cou				yn Park		4c. County o Anne Ar	
Physic /Medi		Carl Kelly III					February	19, 20	

State of Maryland / Department of Health and Mental Hygiene 904 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 6:30 AM KOVELMAN 02 VIVIAN 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bultimore oF Bultimore N/A SINAI HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | AUG. 28, 1926 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F Director 117-18-5766 NY Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits f show in then "natural", or itema 23a or 28a-f ehove the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7939 LONG MEADOW ROAD 21208 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: 3 X Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental ဂ **ESTHER** WEINER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 HARRY KOVELMAN / 7939 LONG MEADOW ROAD - BALTIMORE, MD 21208 SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Name Burial 2 □ Cremation 3 Name Removal from State
4 □ Donation 5 □ Other (Specify) 6 permit. Page Department of Important: if any injury or once. 2/22/2004 CEDAR PARK CEMETERY EMERSON, NJ 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Sefsis **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Clisease or Injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) ned by the a detached for 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 🔀 No or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I the Hospital completely filled 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number harles Kes 19,2004 000 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Griffith Do SINAi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 4 2004 Registrar

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 2004 05746 State
Registrar / MEND ITEM #17 PER FH G828 2/24/04 Glertificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 21,2004 **Physician** 7:30 P M **KESSLER** DOROTHY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE MILFORD MANOR NURSING HOME If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Days Months 1□ M 2 F 85 MD 219-07-3539 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. fnside City Limits 10b County 10a State r than "natural", or itams 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 16 OLD COURT ROAD #405 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 💢 No Specify: Specify þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Il Hygiene. College (1-4or 5+) SECRETARY REAL ESTATE CO. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be if Health and Mental 2 should be SETTLER REBECCA REINER MILTON SATTLER 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 TANNER COURT - BALTIMORE, MD 21208 KARREN FRIEDMAN / DAUGHTER 1 and 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iter
any injury or oth 1 A Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) FORBAND CEMETERY 2/23/2004 ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) nlunn **Physician** muner /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner transit the death certificate be executed and ng physicien an Due to (or as a consequence of): Physician/Medical attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ō in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No detached 9□ Unknown 9 Unknown δ signed t Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \[\text{Yes} \] 2 \[\text{No} \] 24a. Was an has page 2 autopsy performed certificate 2 NO director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Yes 2 ER/Outpatient 3 DOA Sich funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural 5 Pending investigation death. 1 Tes 2 No 2 Accident Director 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after 4 Homicide 24 hours a Learnitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examination: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. the ţ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 0 0 D27569 Green Tree Rd 30. Name and address of o completed cause of death (Item 23a) (Type, Print) 1 31. Date filed (Mont 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore.

Records, P.O. Box 68760,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene 05747 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 20,2004 **Physician** Madeline В. Kraus 5:56AM M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 11622 Sitting Bûll Court Lusby Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 22, 1909 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 ☐ M 2 ☑ F 94 Maryland 214-01-1834 Director Usual Residence of Decedent i Hygiene. other than "natural", or liems 23a or 28a-f show vent, the Medical Examinar must be rivified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 21 No MD Calvert Lusby 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11622 Sitting Bull Court 20657 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

In marked other than "natural", or Ite Imprication any injury or other traumatic event, the Medical Examina 1 Never Married 2 Married 2X No 1□Yes 2□No Baltimore, Maryland 21215-0036 Specify: White Specify. à 3 □ Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Loan Officer Loyola Federal 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Adolph Buschman Marie Antoinette Athman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Philip V. Kraus - Son 809 Dora Place Bel Air, Maryland 21014 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 2/27/04 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Heather Cain 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death movascular accident Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physiclan/Medical Examiner Due to (or as a consequence of) use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be Completed by 1 ☐ Yes 2, No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? res 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one) Medical Certification; To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and address B. Sylvia Batong, M.D. 11845 H.G. Trueman Rd., Lusby, 20657 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 2 4 2004 Bellen! Registrar

		1	State of Maryland State of Maryland Registrer		artment of H		d Mental Hyg	giene Rag. No. 2	004	05748
	Physicia		1. Decedent's Name (First, Middle, Last) Eldon L.	Le	wis		2. Date of Dea Month	ath Day	Year 0 0 4	3. Time of Death 9:20an
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or	Location of De	1200		unty of Deat	h
	Examin	eı	Ivy Hall Nursing Center		Mid	dle Ri			ltime	ore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Year Months Days		Irs. 8. Date of Birt (Month, Da) Aug25	h y, Yeer)	9. Birt	hplece (State or Foreign WChCarolina
	Director		250-24-6228	Yrs.			Aug25	, 1918	30	delicaloffila
	pu »	-	Usuel Residence of Decedent 10a. State 10b. County 10c. City, 3	Town or Lo	cation					10d. Inside City Limits
	sho	ò	MD Baltimore			dle Ri	ver			1 ☐ Yes 2 🛣 No
	the M	ecte	10e. Street and Number		10f. Zip Code			10g. Citizen	of What Co	untry?
	with	Funeral Director	2135 Redthorn Road			220		USA		
	ns 23	era	11 Marital Status 12. Was Decedent Ever in U.S.	13.			(Specify Yes or No- lerto Rican, etc.)		Race - Ame	ncan Indian,
	r Itan	Fun	1 ☐ Never Married 2☐ Married IT → Yes 2 ☐ No IT → Yes (Sive	i i			ierto Hican, etc.)		Black, Whit	
8	al', o	ρχ	3 Widowed 4 Divorced Year or Dates:		1□Yes 2√□No	Specify:		Sp	^{eciħ} ₩hi	te
5-003	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of	working	16b. Kind	of Business/	Industry
2121	ithin Jen	du	Elementary/Secondary (0-12) College (1-4or 5+)		achines			Bot	h St	001
2	be filed within 72 hours after death with the Maryland lat Hygiene. Id other then "natural", or Itams 23a or 28e-f show event, tre Medical Examinar must be multiped at		6th 17. Father's Name (First, Middle, Last)	Li	achines		Name (First, Middle,			
Maryland	e d its	Be	Charles Lewis			unkn			,	
ž	should be ind Menta inarked imartic ev	10		19b. Mailir	na Address (Street		Rural Route Numbe	er, City or To	wn, State, 2	Zip Code)
<u>8</u>	and 2 sho Balth and n 27 is mu er traum		Paula Sullivan / daughter		-		rive Ba			
<u>6</u>	Heal Heal tem		20b. Place	ce of Dispo	sition (Name of	!	Date	20c. Locati	ion - City or	Town, State
more,	Pages nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hol	lyHi	natory or other place 11Cemet	ery 2/	26/04	Balt	imor	e MD
Baltii	그 된 원 중 .		21. Signature of Funeral Service Licensee					Funer	alHo	meofEssex
ä	Depa Impo any in		1. Terry Connelly		300	Mace A	ve. Bal	timor		
-	*		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	-Do not ent				rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	200	Prost	rate	2.			Onset and Death
	/Medical		resulting in death) Due to (or as a conseque							
	Examiner		Sequentially list conditions, b.							
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Ú.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events c	nce of):						
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687	tificate ig phys as the		V							
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Records,	ne law r n has be ge 2 sh	Completed	- Cerebro-Vascular a	cci	ani.		24a. Was		4b. Were au prior to death?	utopsy findings available completion of cause of
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on	ffe ffe	tlon	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	f 28c. Injur Wor M 1 []	k? Yes 2 □No				
Division of Vital	Attending at death.	fica	3 Suicide 6 Could not be 28e. Place of Injury - At hom	ne, farm, st	reet, factory, office		28f. Location (. City or To		lumber or R	ural Route Number,
á	s after	Certification:	4 Homicide determined building, etc. (Specify)				0.19 0.701	wii, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier (Check only 2 Medicel Examiner: On the basis of examination			-ining death -	and an about the	data and mid	and du	to the course(s)
	thin 2.	Medical	29b. Signature and title of certifier 30. Name and address of person who completed gause of death (Item 2) 13 1 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature and Month (Item 2) 13 12 13 12 13 12 13 12 13 12 13 12 13 12 13 13 13 13 13 13 13 13 13 13 13 13 13	1	29c. Licens	se number		29d. Date s	igned (Mont	h, Dey, Year)
	A W S		Mind (W.D		D-	179	92	2	-23	-04
	3		30. Name and address of person who completed cause of death (Item 2	23a) (Tvoe.	Print) /	00	1 -	3C/N-	MN	121206
	0		KHIN-M. TUN 1312	Go	ucher	15000	100	SUM	, val	2/200
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	Ire .	1					
	Regist	rar	FEB 2 4 2004	2	aporks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month С. Patricia Lewis Tels 2004 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) The Hebrew Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) Hours Months Days 1□ M 21 F Yrs 298-18-9458 Ohio AUG 8, 1922 Usuel Residence of Decedent 10d. Inside City Limits 10a. Sfate 10b. County 10c. City, Town or Location 1 ☐ Yes 2√☐ No Silver Spring Maryland Montgomery 10g. Cifizen of What Country? 10e. Street end Number 10f. Zip Code 20901 USA 10100 Hereford Place 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 157 No If Yes, Give A Yeer or Dates: Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Merried 1 ☐ Yes 2 ☒ No White Specify. Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) 5 + Elementery/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) Florence Price Harold Claflin 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10420 Sweepstakes Road Damascus, MD 20872 Paul N. Lewis/Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-20-04 Metro Crematory Inc. Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Faneral Service Licen MicDonald 299 Frederick Road 21228 Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Atherosclesste Due to (or es a consequence of) Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an eutopsy performed?

Physician /Medical Examiner

physician and s the burial-trensit

this certificate

within 24 hours aftar death.

To the Funeral Director: At complately filled in by tha fu

Hospital

P.O. Box 68760,

Records.

Division of Vital or Attending Physician: Physician/Medical Examiner

Completed by

Be

Certification: To

Medical

Department of Important; if it any injury or o

Baltimore, Maryland 21215-0020

Hygiene.

Pages 1 and 2 should be filed w tment of Health end Mantal Hygies tant; if item 27 is merked other th jury or other traumatic event, the

Physician

Examiner

Funeral

Director

/Medical

Funeral Director

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Be Completed

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Neturel

2 Accident

3 ☐ Suicide

24b. Were autopsy findings available prior fo completion of cause of death?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify)

25.	was case examiner?		10	medical
	1 Yes	2 1No		
27.	Manner of	Deeth		

28e. Date of Injury (Month, Dey Yeer) 5 ☐ Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

4 ☐ Homicide 29a. Certifier

6 Could not be determined

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29b. Signature and title of certifier

29c. License number

Other:

29d. Date signed (Month, Dey, Yeer)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

weil mile

State Registrar Mon trose Road 32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2004 05750 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Eugene Lowry 9:00 P M February 22, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** EastPoint Rehab & Nursing Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 451-28-1280 Director 81 Nebraska June 3, 1922 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show Examiner must be notified at 1 Yes 2 No Director Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8405 Kavanagh Rd. 21222 U.S.A. "natural", or Itama 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Nav Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 11th than College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, than X-Ray Service Technician Hospitals 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Hayes Lowry Elizabeth Ona Holzman ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Lowry / Wife 8405 Kavanagh Rd., Balto., Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore-Washington 2- 25 -04 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Md. 22. Name and Address of Facility Bradley—Ashton—Matthews Funeral Home, Inc. 233 Party. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a superior of the property of the p Approximate Interval Between Onset and Death ARTERY DISEASE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospitat or Attending Physicien: The law requires that the death certificate be executed Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 DEctopic pregnancy ō Year Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 DrUnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed certificate 1□ Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 20 No 2 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation death. Director: 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by within 24 hours after To the Funerel Direct 4 Homicide ortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To the 29b. Signaturand title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 2 4 2004 Registrar DHMH 17 Rev 1/2001

ORIGINAL

		1 - For Unpend ITem#23a	State of Ma ,27,Per MEG	ryland / Depa 83 0,4/2/0/68	artment of Hortificate of E	ealth and Death	Mental Hy	giene 2 (004	05751	
Dhari		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath Day	Yeer	3. Time of Death	
Physic /Med		Deborah L.	·	Februar		NA.					
Exami					4b. City, Town, or	h	4c. County	4c. County of Deeth			
		Franklin Square F 5. Social Security Number 6. Se		(In yrs. last birthday)	Rose	dale If Under 24 Hrs	R Date of Birt		ltimor	Ce (State or Foreign	
Funeral Director			□M 2XF 4		Months Days	Hours Min.		, Year) 1956	Country	ryLand	
D		Usual Residence of Decedent		10c. City, Town or Lo			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,			
Ind 21215-0036 be filed within 72 hours after deeth valat Hygiene. of other than "naturel", or items 23 event, it a Medical Examination.	-	10a. State 10b. County			100	d. Inside City Limits 1 ☐ Yes 2 1 ☐ No					
	Director	Maryland Balti 10e. Street and Number	ESSEX 10f. Zip Code 10g			10g. Citizen of	M/hat Causti				
	2	1400 Browning Dr.	21221			-	S. A.				
	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of His If Yes, specify Cubar		Specify Yes or No-	- 14. Rad	ce - Americar	n Indian,	
	b	1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 🛣 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	es 2.10 No Give 1 □ Yes 2.20 N					Black, White, etc. Specify: White		
	Completed	(Specify only highest grade completed) (Give life.			e kind of work done during most of working DO NOT use retired)			16b. Kind of B	6b. Kind of Business/Industry		
	nple										
		8th Grade 17. Father's Name (First, Middle, Last)	Homemake	(Cina Middle		Own Home					
	Be C	Harry Miller	18. Mother's Name (First, Middle, Ma. Lorraine Morra				,				
should be not Mental marked of marke	2	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailie	ng Address (Street a				VL ity or Town, State, Zip Code)		
≥ 5 € 7 F		Paul Tenny (Frien	d)					t H, Essex, Maryland 21221			
Ore, of Hea of Hea ritem		20a. Method of Disposition	·	20b. Place of Dispo	osition (Name of matory or other place	9)	Date	20c. Location	- City or Tow	n, State	
Peges Peges nent of ant: If it		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		Oaklawn	,		/2004	Baltimo	re. Mi	aryland	
Baltimore, permit. Peges 1 ar Department of Hea Important: If item any injury or othe once.		21. Signature of Funeral Service Licen	100		2. Name and Address 3331 Brehm	s of Facility Sc	himunek	Funeral	Homes		
		23a Part 1. Enter the disease, or comp	ligations that caused	the death. Do not ent					A	Approximate nterval Between	
) Physician		shock, or heart failure. List only the limmediete Cause (Final disease or condition		lerotic Cardi	iovascular D	isease				Onset and Death	
/Medical		resulting in death)									
Examiner	_	Sequentially list conditions,									
ed sit	line	cause Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence									
xecut and	Examiner):						
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o.O. Box 68760, at the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						te of delivery onth Di	yay Year	
# 2 B	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?			
requirements							1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐			oly 4 □Unknown	
	Completed						24a. Was a	an 24b. \	Were autops	y findings available	
The I	E O		auto			sy prior to completion of cause of med? death? 2 \[\text{No} \] 1 \[\text{Yes} \] 2 \[\text{No} \]					
	Be (25. Was case referred to medical examiner?					ath (Check only or				
	2	¥T Yes 2□ No	Hospital:			4 Nursing H	lome 5 Resid				
On O ding Ph h. After th funeral	lon	27. Manner of Death 1 ♣ Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Work?			e how injury occurred			
Hospite 4 hours Funerel iely filled	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)			M 1 Yes 2 No		28f Location /S	cation (Street and Number or Rural Route Number,			
	erti							own, State)			
	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To the within 2 To the complet	₩	29b. Signature and title of certifier			29c. License number O.C.M.E.		29d. Date signed (Month. Day, Year) February 21, 2004				
		30. Name and address of person who o	ompleted cause of de	ath (Item 23a) (Type,	Print)						
		MARYAMOR A	KORGU	11	1 Penn St	reet, Ba	ltimore,	Maryla	ind 21:	201	
St Regist	ate rar	31! Date filed (Month, Day, Year)	32. Registrar		hoorkel						
DHMH 17 Rev 1/	-	FER 2 4 2004	6 State of the	100	par vermen						

State of Maryland / Department of Health and Mental Hygiene 2004 05752 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Dav Month Year LOBE **Physician** BERNARD R. 4:07 2004 Pebruary 22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE N/A UNION MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months XX M 2□ F Yrs. 65 217-34-8569 08-06-1938 MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Inter it item 27 is marked other than "natural", or items 23s or 28s-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examinations the notified at PIKESVILLE 1 Yes 2XXVo BALTIMORE MD. Ö Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21209 U. S. A. COURT 38 STRIDESHAM Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2XXNo WHITE Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)
ONE YEAR Elementary/Secondary (0-12) MEDICAL SUPPLY COMPANY OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HERMAN NAPOLEON BONAPARTE LOBE, JR. LILLIAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Heatth ar Important: If item 27 is any injury or other treu once. 38 STRIDESHAM COURT, PIKESVILLE, MARYLAND, 21209 ELIZABETH R. LOBE (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 02-25-2004 BALTIMORE, MARYLAND HEBREW FRIENDSHIP CEM. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD N. Kuth RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD., 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Occipital Immediate Cause (Final disease or condition resulting in death) lobe bleeding Iweek Physician /Medical (or as a consequence of) **Examiner** cerebe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 2 months use as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of defivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ deno Carcino ma 3 Probably 4 Unknown 1

Yes 2□No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificate has page 2 performed 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA After this funeral 28a. Date of Injury (Month, Day Year) 28d Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 D0056046 22/04 The Union Memorial Hospital, Bultimore legistrars Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 4 2004 Registrar

	1 - For State Registrar	State of Ma	aryland / De	partment of I	Health and M	lental Hygie		05753
Physician /Medical	Decedent's Name (First, Middle GL	ORIA	S.	LESTNE		2. Date of Death	^{Da} Y9, 2004	3. Time of Death 6:00 P M
Examiner	JEWISH CONVALE	SCENT CENTER		BALTIM		2 2 2 4 2 4 2	4c. County of Death	ORE
Funeral Director	5. Social Security Number 134-14-2757 Usual Residence of Decedent	1 M 2 K	e (In yrs. last birthda 78 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye JULY 29,	1925 9. Birth	place (State or Foreign Intry) NY
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Wher then *natural; or Items 23a or 28a-f show after then *natural be notified at any from the first filed at a Completed by Funeral Director	10a. State 10b. County	LTIMORE	10c. City, Town or BAI	Location _TIMORE				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with the 23e or 28 set be no	10e. Street and Number 7920 SCOTTS LE	VEL ROAD		10f. Zip Code	21208	10g.	Citizen of What Cou	U.S.A.
within 1.2 nous area dean with the wayan with the mayares or then "natural", or items 23e or 28e-f show it. The Medical Examinar mast be notified at Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? ad 1 Yes 2 X I Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🎇 No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
than "natur than "natur ha Medical proprieted	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or 5	(G life	cedent's Usual Occupive kind of work done DO NOT use retire	during most of work	ing 16b	b. Kind of Business/li	RETAIL
a b w	17. Father's Name (First, Middle, I	ast)		_KIND	18. Mother's Name	e (First, Middle, Maid		NZINGER
f Health and Menite other traumatic	19a. Informant's Name/Relationsh RICHARD LESTNE			ailing Address (Street			ity or Town, State, Zi	p Code)
o == =	20a. Method of Disposition 1 ABuriai 2 □ Cremation 4 □ Donation 5 □ Other (S)		cemetery, c	sposition (Name of Frematory or other pla	ice)	1	DUNDALK	
Department important: any injury conce.	21. Signature of Funeral Service I	WII D	- '	22. Name and Addre		L LEVINSO	N & BROS.	, INC.
nysician Medical xaminer	23a. Part 1. Enter the disease, or shock or he in failure. List Immediat Cause (Final disease or condition resulting in death) Sequentially list conditions, any lagging to immediate	a. Due to (or as	a consequence of:	enter the mode of dyi	ng, such as cardiac d	or respiratory arrest.	af	Approximate Interval Between Onset and Death
onysician and the burial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
d by the attending physicii etached for use as the but ached for use as the but by sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у	7.7	23d. Date of deliving Month	ery Day Year
be d	Part II. Other significant condition	ns contributing to death b	ut not resulting in the	e underlying cause gr	ven in Part I.		co use contribute to	the cause of death?
cate has been single page 2 should I						24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
this certificate al director, pag	25. Was case referred to medical examiner? 1 Yes 2 No		ent 2 ER/Outpa	tient 3 DOA		n (Check only one) me 5 🗆 Residence	e 6 □Other (Speci	íty)
after death. Director: After to a in by the funera ertification:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investig	ation	ry 28b. Time y Year) Injur	y Wo	ryat rk?]Yes 2 □No	28d. Describe how i	njury occurred	
rs after death al Director: , led in by the f	3 Suicide 6 Could r 4 Homicide determ	of be ned 28e. Place of Inj building, et	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Street City or Town, S.	t and Number or Run tate)	al Route Number,
within 24 hours after death. To the Funeral Director: After this certification to the Funeral director. After this certification. Medical Certification: To Be C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best examiner: On the basis o and manner st	t examination and/oi	eath occurred at the ti investigation, in my o	me, date and place, opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as s and place, and due t	stated. to the cause(s)
	29b. Signature and title of certifier	16M		29c. Licens	15575	3 100	Date signed (Month,	
3	30. Name and address of person	who completed cause of d	leath (Item 23a) (Typ	on, Print)	of 21	136)	
State Registrar	31. Date filed (Month, Day, Year) FEB 2 4 2	32. Registr	ar's Signature	seles				

State of Maryland / Department of Health and Mental Hygiene 05754 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}20, 2^Y004 **Physician** FEBRUARY L LESSER MATILDA 4:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SPRINGHOUSE ASSISTED LIVING PIKESVILLE BALTIMORE If Under 24 Hrs. 8. Date of Birth Month, 1911 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F Months 93 056-01-5764 Yrs NY Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8911 REISTERSTOWN ROAD 21208 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (1) No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME . Pages 1 and 2 should be filed wi frinent of Health and Mental Hygien tant: if item 27 is marked other th jury or other traumatic event, that 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be METZ WILLIAM YETTA KRITZER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA SCHER / DAUGHTER 9050 IRON HORSE LANE #411 - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Bunal 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. NEW MONTEFIORE CEM. 2/23/2004 PINELAWN, NY Funeral Service Incenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death 1PHYSEM A Immediate Cause (Final **Physician** YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physicien and s the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No detached o. the 9☐ Unknown ģ Division of Vital Records, P. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MALNUTRITION 1 Yes 2 No 3 Probably 4 Unknown Completed peen : 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has certificate 1 Yes 2 No 25. Was case referred to medical examiner? ASSISTED funeral director. Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 XOther (Specify) LIVING 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of After t or Attending Natural 2 Accident Injury To the rucepuse to within 24 hours after death.

To the Funeral Director: After the Funeral Director of the fun 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 1838 GREENE TREE Rd Suite 300 WALEN MA HARRY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 21208 & Sporks FEB 2 4 2004 Registrar

38	2		. For	State of Ma	aryland / D	epartment of H	lealth and M	fental Hy	giene 2	004	05755
-			1 - State Registrar 1. Decedent's Name (First, Midd			Certificate of	Death	2. Date of De	Reg. No.		3. Time of Death
	Physicia		LARRY	WAYNI	E	MACRANDE	R	Month FEBRUA	Day	Year 2004	1055 A ^M
	/Medic Examin		4a. Facility Name (If not institution 19 ROBINWAY CO	•		4b. City, Town, o	r Location of Death			ty of Deeth	
	Funeral Director		5. Social Security Number 530–22–8238	6. Sex 1 X X 2 □ F	ge (In yrs. last birti	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 08/03/1	th 19, Year) 939	9. Birthpl Coun WA	ace (State or Foreign try)
	pu \star 🗆		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town	or Location				10	od. Inside City Limits
	Maryla R-fahov	ctor		IMORE	PERRY						1 ☐ Yes XXNo
	with the	Funeral Director	10e. Street and Number 19 ROBINWAY	COURT		10f. Zip Code 2123	6		10g. Citizen o		try?
	death ima 23	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of H If Yes, specify Cub	dispanic Origin? (Sp	ecify Yes or No		ace - America lack, White, e	
020	s i and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. To it man 23a or 28a-f ahow other traumatic event, the Medical Examinations to incitinate at	þ	1 Never Married 2 Mai	rned XXYes 2 1	No	1 □ Yes 2 X [X]o			Spec		ITE
ה ה	"natu	etec	15. Deceder (Specify only higher	nt's Education est grade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	ation during most of work d)	aing	16b. Kind of	Business/Ind	ustry
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2	be filed tal Hyg d othe	Bec	17. Father's Name (First, Middle				18. Mother's Nam			ame)	
2	should be ind Mental is marked c	2	ERNEST ELWOOD 19a, Informant's Name/Relation		19h	Mailing Address (Street		CE MARY		n. State. Zio	Code)
=	and 2 shu salth and n 27 is m		RITA E. ATKIN			502 NELSON					
ש	Pages 1 and 3 nent of Health int: If Item 27 iry or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (cemeter	Disposition (Name of y, crematory or other pla L HILLS CEM	ce)	Date	20c. Location		
	그든뿐군		21. Signature of Funeral Savice	Licensee	VESTA	22. Name and Addre			VESTAI RAL HON	IE, PA	S, NI
Ŏ	Depar Impor		KELLY GRE	GCRY FINK #MO	01148	426 CRAIN				MD 21	
	Physician /Medical		23a. Part1. Enter the bisease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a time	entersix	a Mexico	s such as cardiac	or respiratory a	Mozula		Approximate Interval Between Onset and Death
a) a)	Examiner			Due to for as	a consequence of	of):					
	led sait	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of	of):			-		
,00	be executed ician and burial-transit		that initiated events resulting in death) Last	C. Due to (or as	a consequence of	of):					
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XOO	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 ☐Ectopic pregnanc 5 ☐ Other (specify)	у			Date of delive Month	ry Day Year
	the de by the a	nysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	tt time of death	J Other (specify)					
cords, r	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by	Part II. Other significant condit	ions contributing to death b	bul not resulting in	the underlying cause gr	ven in Part I.	1	obacco use co Yes 2 □ No		e cause of death? ably 4 Dunknown
d)	e law rec has bee je 2 shou	ompieted						24a. Was	psy		osy findings available inpletion of cause of
	Thate at a	Con						Yes	ormed? 2 ☐ No	1 Yes	2□ No
N Ear	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medic examiner? 1 X Yes 2 No	Hospital: 1 ☐ Inpati	ient 2 ER/Ou	tpatient 3 DOA Ot	26. Place of Deather:	th <i>(CH</i> eck o <i>nly c</i> ome 5⊟ Resi		ther (Specific	AT SCENE
	ng Phys ter this neral dir	on: To	27. Manner of Death Natural 5 ☐ Pend	28a. Date of Inju	ury 28b. T	ime of 28c. Injury Wo		28d. Describe			AI OCLINE
DIVISION	I or Attending Phatter death. Director: After the	catic	2 Accident inves	tigation	ius. At homo fa	M 1 mm, street, factory, office]Yes 2□No	28f Location /	Street and Nur	mber or Rura	Route Number,
	tal or Al s after o al Direc ed in by	Certification:	4 ☐ Homicide deter	mined building, e	tc. (Specify)	m, street, factory, onice			wn, State)	nosi di rigia.	riodio itambor,
	To the Hospital within 24 hours a To the Funeral C completely filled it	Medical (ing Physician: To the best il Examiner: On the basis of and manner st	of examination and						
	within To th	Me	29b. Signature and title of certif	led 1 1		29c. Licen	se number OCME		29d. Date sign FEBRUA		Day, Year) , 2004
	X,		30 Name and address of perso	n who completed cause of							
	<u> </u>	(J. LAKON	Dec M) TII be	enn Street,	Baltimore	e, Mary	Land 21	201	

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Registrar

State 31. Date filed (Month, Day, Year)

FEB 2 4 2004

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Z -1chair uscione 500 G M /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Vocobine If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 1 € M 2 □ F 218-14-9637 87 Yrs. Director Sept 9 1916 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28e-f show show 10d. Inside City Limits Md Howard Director Woodbine 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ freumatic event, the Medical Examinating be 14770 Bushy Park 238 USA 21797 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No WWIT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married ŏ Maryland 21215-0036 1 Yes 2 No Completed by 3√z Widowed 4 □ Divorced Specify.White Year or Dates: "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Howard Co. Roads maintenance worker C. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! Pages 1 and 2 should be James Howard Musgrove Rachel Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a Marianne Livesay (executor) 890 River Rd., Sykesville, Md 21784 injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Important: I any injury o Sykesville, Md All County Cremation 2-23-04 permit. 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses though Hought P.O. Pox 195 Sykesville, Md 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence ot) Examine The law requires that the death certificate be executed burial-transit Reu Due to (r is a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of deliver 3 Ectopic pregnancy for 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month 5 Other (specify) o. the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 99 Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate overnar Division of Vital 1 ☐ Yes 2 No director, 25. Was case referred to medical / examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Tes 2. No 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospitel or t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 namin T 31. Date filed (Month, Day, Year) 0 0,001 gistrar's Signature 32. State FEB 2 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Dav 417, 2004 4c. Cognity of Death Theodore nyvary /Medical McCoy 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Mercy N/A Balto 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours XXM 2□ F Yrs. Director 247-68-2428 63 9-8-1940 S.C. Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other treumatic event, the Madical Examiner must be notified at 10d. Inside City Limits Md N/A Baltimore Directo tv Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1800 Hollins Street Funeral Apt 427 USA 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ No Specity: δ 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade N/A Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Benjamin Brunson Maggie China 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise James - Sister 611 G. Cherry Crest Road Balto, Md 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, cramatory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) King Memorial Park 2-23-04 Randallstown, Md 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 23a. Part1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical CUNCCI Examiner Due to (or as a consequence of) Examiner physician end s the buriel-trensit The law requires that the deeth certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate nes been signed by page 2 should be detec 3 Probably 4 Unknown Ves Yes 2□ No ٥ Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TLIYes 2 MNO 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Medical Certification: To 1 Yes 2 No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Matural cours efter death.

Neral Director: Aft
filled in by the fur 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 30 31. Date filed (Month, Day, Year) 82. Registrars State Registrar DHMH 16 Rev 6/95

ORIGINAL

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** M14/18/1 KEUIN 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NI RICHEC 405 PICE BAITHOR 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Days 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year 1 XM 2 ☐ F Yrs. Director 218 82 2158 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumstic event, the Medical Examiner must be notified at 10d. Inside City Limits BALLINERE 1 Ves 2 □ No Directo HAVY MAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AUZ USM 2/2/6 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 Tes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 8/ccle Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ABOIEN TVIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JEAN HIRACII THOMA WILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FEAN LNG MUTHEN 2916 WESTEROOD BALTINOR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1.28urial 2 □ Cremation 3 □ Removal from State permit. Page Department of importent: If any injury or once. Compter BAL HAUR 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fymeral Service Licey BATTIMA & MMO NU 313/1 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ALDS 4eArs /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? menu 1 Yes 2 No 3 Probably 4 19 briknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No 1 ☐ Yes 2 12 No To the Hospital or Attanding Physicien: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) el il D44715 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STPAUL STRAIN FRANCIS D. 121 501 31. Date filed (Month, Day, Year)... 32. Registrar's Signature State Registrar

ORIGINAL

Mitchel

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	Physici		1. Decedent's Name (First, Middle, Last CLAUDE MCK		5			2. Date of Death Month	Day Year	3. Time of Death
}	/Medio Examir		4a. Facility Name (If not institution, give	street and numbe	9r)		r Location of Dea	FEBRURRY th	4c. County of Deeth	
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	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		10c. City, Town or Lo	Baltimo	re			10d. Inside City Limits 1∭Yes 2 ☐ No
	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f show fre Mexical Examinar name Learning at	Funeral Director	10e. Street and Number Seton 500 Druid Hill Av 11. Marital Status				201 lispanic Origin? (S		g. Citizen of What Cou U. S. 14. Race - Ameri	A . can Indian,
-0036	2 hours after atural; or ite	b	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	1 Tes 2) If Yes, Give Year or Date:	() No s: 16a. Dece	1 ☐ Yes 2 No	Specify:	16	Black, White Specify: W	iite
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Maryland	should be fand Mental I	To Be	Dr. Leslie B. Hohi 19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street	Eunic	e McKenzi	,	o Code)
Baltimore, M	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f ahow any injury or other treumatic event, the Macical Experiment natal by notified at ance.		Mrs. Ann McKenzie 20a. Method of Disposition 1 X Burial 2 Cremation 3 F 4 Openation 5 Other (Specify)		20b. Place of Dispo	sition (Name of natory or other place	(9)	Date 20	Maryland Oc. Location - City or To X Land Nan:	
Balti	permit. Departm importa eny inju		21. Signature of Funeral Service Ricens	lami	3.	Name and Address 331 Brehm	ss of Facility S & Lane,	Schimunek Baltimore	Funeral Ho , Maryland	mes
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8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		as a consequence of):					
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	w requires that been signed b should be deta	by	Part II. Other significant conditions con		_	nderlying cause give	en in Part I.		cco use contribute to the	ne cause of death?
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Division of Vit	Attending Physicier ir death. ector: After this certif by the tuneral directo	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No F 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpa 28a. Date of In (Month, D	iury 28b. Time of	ent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) of 28c. Injury at 28d. Describe how injury occurred				
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			30. Name and address of person who co TZYAN MCCORMACI 31. Date filed (Month, Dec Year)	< 22	South Green	e Strop	t BAI	TIMORE,	MD 212	-01
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		/Medic Examin		Mary M. Mort 4a. Facility Name (If not institution, g			4b. City, Town, o	or Lecation of Death		c. County of Death	
		LXUIIIII	٠.	Good Samar	itan Hogoi	tal	13a 1-	timore		NA	
		Funeral Director		5. Social Security Number 6 219-46-5286	Sex 7. Age (ln yr. 1 □ M 2 ☑ F 57	s. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Dey, Yea Dec. 25, 1	9. Birthpi Coun 1946 Mas	lace (Stete or Foreign try) 55 •
	pug	≥		Usual Residence of Decedent 10a, State 10b, County	10c. (City, Town or L	ocation			11	0d. Inside City Limits
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	laryla Sepondo	Men	To	Leo Z. Robitai		405 44-1	in Address (Canad	Margaret and Number or Rura	Rooney	or Town State Zin	Codol
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	Baltir	Department Important: I any injury o		21. Signature of Funeral Service Lie			2. Name and Addre				Home, Inc.
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_	HOROCO.	/Medical xaminer		resulting in death)	Due to (or as a cons	sequence of):		1	\$72		
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	Division of Vital Records, P.O. Box 68	nyste nis ce I direc	2	examiner?		ER/Outpatio	ent 3L DOA		ne 5 Residence		1)
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	sio	tor: /	icati	2 Accident investigated and Suicide 6 Could not	ot be 280 Slace of Injury - At	t home farm s]Yes 2□No	28f. Location (Street	and Number or Rura	I Route Number.
	iz i	or A after of Dirac in by	Certification:	4 Homicide determin	building, etc. (Spe	ecify)	illest, lactory, office		City or Town, Sta		, riodio rambor,
	_	To the Posts all the factoring Priystrian; The factoring the within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	(Check only 2 Medical E	Physician: To the best of my k xaminer: On the basis of exam	knowledge, dea ination and/or	ath occurred at the t nvestigation, in my	ime, date and place, a opinion, death occurre	and due to the cause ad at the time, date a	(s) and manner as si nd place, and due to	ated. the cause(s)
		vithin 2 To the Complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen	se number	29d. D	ate signed (Month,	Day, Year)
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		10		30. Name and address of person w		Item 23a) (Type	e, Print)		100	· VIVITY	1
	_	1		Elias 199a	5601 LOCH	Kaver	1 (9/VC).	Baltime	ove, MD	21239	23,2004
		Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	1 43	1 /			

DHMH 17 Rev 1/2001

Morton, Mary

			1 - For State Registrar	State of Maryl	and / Depa <i>Ce</i>	artment of H	lealth and <mark>f</mark> D <i>eath</i>		ene 20	04 05761
n He	Physici		Decedent's Name (First, Middle, Last) Joseph	Thomas	McCor	rmick		2. Date of Death		3. Time of Death 004 5:50 P M
}	/Medic Examin		4a. Facility Name (II not institution, give s Greater Baltimore	Medical Cen	ter	4b. City, Town, or Towson	Location of Death		4c. County of Baltimo	Death
E _q	Funeral Director		5. Social Security Number 6. Sex 177-24-1654		(rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,)	(ear)	Pennsylvania
	he Maryland 18a-1 ehow	ector	10a. State 10b. County Maryland Baltimor		City, Town or Lo	lle				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow ha Medical Examinat must be motified at	by Funeral Director	10e. Street and Number 1611 Pinnter Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever i Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 1955 Year or Date 1955		10f. Zip Code 2109: Was Decedent of H if Yes, specify Cuba 1 □ Yes 2 ☑ No	ispanic Origin? (Sr	pecify Yes or No-		American Indian, White, etc.
Maryland 21215-0036	d within 72 hour piene. r than "natural"	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Dece (Give life.	dent's Usual Occupi kind of work done of DO NOT use retired	during most of won	king	Sb. Kind of Busin	White mess/Industry Public Schools
ryland 2	hould be filed d Mental Hyg narkad othe natic event,	To Be C	17. Father's Name (First, Middle, Last) Stanley M. 19a. Informant's Name/Relationship (Typ.	McCormick	•		18. Mother's Nam Beatr	ne (First, Middle, Ma	widen Sumame) Walke	r
Baltimore, Mai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural; or Items 23a or 28a-1 show may injury or other traumatic event, the Medical Examiner must be natified at once.		Kathleen M. McCorm 20a. Method of Disposition 1 Burial 2 Cremation 3 Rev. 4 Donation 5 Other (Specify) 21. Sin ature of Funeral States to License	ick Wife amoval from State D	1611 b. Place of Dispo u faney right Memorial	Pinnter F sition (Name of nation) or other place a liney Gardens	Road Lut	Date 20	Maryla oc. Location - Ci imonium Funera	nd 21093 tyorTown, State
	Icate be executed /Medical Examiner s the buriat-transit	ical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):	er the mode of dyin.	1 1	or respiratory arres	1.1	Approximate Interval Between Onser and Death
O. Box 68	ne death certif the attending thed for use a:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Sc. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
۵.	sign d be	by	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause give	en in Part I.			te to the cause of death? Probably 4 Unknown
	The ate h page	Completed	25. Was case referred to medical						d? dea	re autopsy findings available to completion of cause of th? Yes 20 No
o	aing Phys After this funeral di	ation. To Be	exammer?	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injury Work	or: 4 🗆 Nursing Ho	th Check onl one ome 5 Residence 28d. Describe how		(Specify)
Division	tal or Attendi rs after death al Director: A ed in by the f	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office	Ī	28f. Location (Stree City or Town, S		or Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	ope) 21 Medical Examin	cian: To the best of my er: On the basis of exam and manner stated.	knowledge, death nnation and/or inv	estigation, in my op	oinion, death occur	red at the time, date	and place, and	due to the cause(s)
}	2 X /	-	29b. Signature and title of certifier 30 Name and address of person who can	JULIU npleted cause of death (Item 23a) (Type,	29c. License	36814	1	Date signed (A	Aonth, Gay, Year)
	Sta Registr	-	31. Date filed (Month, Day, Year) FFB 2.	4 15 D	5 09	iar D	R, Sur	1E302	7020	sbn MD

	1 - For State Registrar	State of Mi	aryland / Depa <i>Cer</i>	tificate of t	Death		g. No.	4 05762
Physician /Medical	1. Decedent's Name (First, Middle, Thomas		rousek			2. Date of Death Month February	Day Year	3. Time of Death 20:18 P M
Examiner	4a. Facility Name (If not institution, g Greater Baltimo:		Center	4b. City, Town, or Towson	r Location of Death		4c. County of De Baltimo	
Funeral Director	5. Social Security Number 218-68-5262	.Sex 7.Ag ↑☐ M 2☐ F	e (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April I() 1954 9. B	irthplece (State or Foreign Country) Maryland
show of	Usual Residence of Decedent 10a. State 10b. County Md. Cecil		10c. City, Town or Lo			<u> </u>		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
a or 28a- be notifi	10e. Street and Number 376 Telegraph	Pd		10f. Zip Code 2191	1	10	g. Citizen of What C	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Evant at must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marner 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	No f	Vas Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian,
ygiene. ner than "nature it, ine Medicul E	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	(Give	dent's Usual Occup kind of work done of DO NOT use retired Buyer	during most of work	ang	6b. Kind of Busines	s/Industry
Mental Hyg arked othe attic event, To Be C	17. Father's Name (First, Middle, La Edward Joseph				Teresa	e (First, Middle, M Velenovsk	у	
salth and n 27 is m er traum	Mrs. Diane Marou		376	Telegrap	h Rd. Ri	sing Sun,	City or Town, State, Md. 2191	11
nent of He int: If itan iry or oth	20a. Method of Disposition 1 🖾 Burial 2 Cremation 3 1 Donation 5 Other (Spe		Dulaney V	natory or other place alley mem	n. 2-23	-04	Oc. Location - City o	
Departr Imports eny inju	21. Signature of Funeral Service Li	censee	22	Name and Address	ows of Facility Fund Fr Rd. To	eral Home	i: 21204	
physician and the buriat-transit and the buriat-transit and dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of): a consequence of):	en he	werki	rgl		onset and Death 24 hours 15 dough
the attending prined for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. ff yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	′		23d. Date of d Month	elivery Day Year
been signed by should be detac	Part II. Other significent condition	s contributing to death b	nut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	N	to the cause of death? Probably 4 □Unknown
ate has bee page 2 sho		00	(/		24a. Was an autopsy perform	prior to death?	autopsy findings available completion of cause of ss 2 \square No
leath. tor: After this certification the funeral director cation: To Be	25. Was case referred to medical examiner? 1	tion 28e. Pface of In	ury 28b. Time of	28c. Injun Wor M 1	er: 4 🗆 Nursing Ho	28d. Describe hor	nce 6 Other (Sp w injury occurred eet and Number or i	ecify) Rural Route Number,
Funar ely fill ical	29a. Certifier Certifying (Check only 2 Medical E	Physicien: To the best xeniner: On the basis of and manner st	of examination and/or in	n occurred at the tirvestigation, in my o	me, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner at	as stated. ue to the cause(s)
To the complete	29b. Signature and file of certifier	Well	CM	29c. Licens	- 1 4/3	110	od. Date signed (Mor	
100	30. Name and address of person w	ho completed cause of c	death (Item 23a) (Type,	Print)	RIES ST	Rm 31	13 Raiso	MD 21204

DHMH 17 Rev 1/2001

ORIGINAL

MHM		•	For State Registrar	State o	of Maryland	d / Depa	artment o	of He	ealth ar	nd Me	ental Hy	giene	20	04	05763
	Physician	n	Decedent's Name (First, Middle		a Teresa	Mora	an				2. Date of De Month JANUAF	eath		Year 04	3. Time of Death 7:02 P M
	/Medica Examine		4a. Facility Name (If not institution 2527 WOODWELL	, give street and nu		11029	4b. City, To	wn, or I				4c.	. County		
	Funeral Director		5. Social Security Number 219-22-8455	6. Sex 1 ☐ M 2√2 F	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 \ Months D	rear Days	If Under 24 Hours	Min.	B. Date of Bi (Month, Da OCt.	rth ay, Ye <i>ar)</i> 29 , 19	927	9. Birthpl Count Penn	lace (State or Foreign try) nsylvania
	B Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland E	Baltimore		, Town or Lo	cation			D	undal]	_			0d. fnside City Limits 1 ☐ Yes 2 ☐ No
	vith the	Director	10e. Street and Number	3 33 5	2		10f. Zip Co	ode	21	222				hat Coun	•
9		2	2527 West Wood 11. Marital Status 1 Never Married 2 Marri	12. Was Dec	cedent Ever in U.sorces?		Was Deceden f Yes, specify 1 ☐ Yes 2 ②		panic Origir , Mexican, I	.222 n? (Spec Puerto R	ify Yes or No ican, etc.)		14. Race	Sta - America k, White, e	an Indian,
Maryland 21215-0036	"natural",	leted by	3 √Widowed 4 □ Divorced 15. Decedent (Specify only highes	Year or I	Dates:	16a. Dece	dent's Usual C kind of work of DO NOT use i	occupatione di	tion uring most o	of working	7	16b. K		siness/Ind	White
212	od withir rgiene. er than	Completed	Elementary/Secondary (0-12) 12 Years		(1-4or 5+)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		cret	ary					roce	ery
land	ld be file ental Hy ked oth ic svent	o Re	 Father's Name (First, Middle, John Husovsky) 								First, Middle ret Wa		Sumame	9)	
Aary	2 shours and M is mar	-	19a. Informant's Name/Relationsl Mr. Richard · V.		tornou		ng Address (S					-			
re, h	of Health item 27 othar t		20a. Method of Disposition		20b. Pl	ace of Dispo	Dunmanv sition (Name matory or othe	of	Suit	Da		ndal]		City or To	-222 wn, State
altimore,	mit. Page bartment c sortant: if rinjury or	-	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S) 21. Signature of Funeral Solvice	pecify)	State	k Lawı	n Cemet	cery	7 2/19						Maryland
Ä	Depariment Important		had III	for	W		Duda-Ri 1922 Wi						ndal] Zlanc	1 21 21	222 Approximate
•	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on	each line. thermia	Complia	ickd by						os dis	હ <u>ે</u> ડ્ટ	Interval Between Onset and Death
160	Examiner	er	Sequentially list conditions, if any, leading to immediate	ь	o (or as a consequ										
10	ate be executed sysician and he burial-transit	Examiner										T			
68760	ysicis	cai		d											
Division of Vital Records, P.O. Box 68	Physician: The law requires that the death certifica this certificate has been signed by the attending phiral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregna. birth 2 Petal gnant at time of de nown	death 3	Ectopic pregi Other (speci						23d. Date Mon	of delive	ry Day Year
rds, P	w requires that been signed be should be deta		Part If. Other significant condition	ons contributing to o	death but not resu	ılting in the u	nderlying caus	se give	n in Part I.			tobacco u		bute to the	e cause of death? ably 4 Unknown
l Reco	sician: The law re certificate has bee irector, page 2 sho	Completed											p: di	rior to con eath?	osy findings available inpletion of cause of 2 No
Vita	ysician: is certific director,	Be	25. Was case referred to medical examiner? 1√2√es 2 □ No	Hospital:	Inpatient 2	ER/Outpatier	at 3□ DOA	Othe	-		Check only		6 © t∩tho	r (Specific	COENTE
ion of	Attanding Physic death.	ation: To	27. Manner of Death 1 □ Naturaf 5 □ Pendin 2 ■ Accident investig	g 28a. Date (Mor		28b. Time of Injury		Injury Work		28	d. Describe		. / >		SCENE o Cold
Divis		Certification;	3 Suicide 6 Could I 4 Homicide determ	ined 288. Plac build		10m6				6	537°	a State	Body	M/8	Route Number West
	n 24 hou n 24 hou ne Fune oletely fil	Medical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To th Examiner: On the i and mai	e best of my know basis of examinat nner stated.	wledge, deat ion and/or in	n occurred at i vestigation, in	the time my op	e, date and inion, death	occurred	d due to the	cause(s) , date and) and mar d place, a	ner as stand due to	ated. the cause(s)
•	To the within 2 To the complete	Σ.	29b. Signature and title of certifie	roni	-Pole	l		.icense	number M E						2004
_	8		30. Name and address of person	who completed cae	111 ()	23a) (Туре, МР		Pen	n Stre	eet,	Balti	more	, Ma	rylar	nd 21201
	Stat Registra	- 1	31. Date filed (Month, Day, Year) FEB 2 4	6	Registrar's Signa		and a								
DI	-IMH 17 Rev 1/200	31		7		-									

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004

								Cert	ifica	te of	Death			Reg. N	o. 2 U	104	05	164
			1. Decedent's Name (First, Middle	, Last)									2. Dete of De Month		ey	Year	3. Time o	f Death
4	Physicia /Medica		Bertha Anna Mo	Cubb	in								Feb.	20		004	11:35) AM
	Examine		4a Fecility Neme (If not institution			umber)					4b. City, To	wn, or L	ocation of Deat	h 4	c. County	of Deeth		
			Manor Care- Rux	rton							Towso	n			Balt.	imore	ž	
	Funeral		5. Social Security Number	6. Sex		7. Age (In y	rs. last bir	thday)	If Und	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th V Year	r)	9. Birthp	lece (State	or Foreign
ы	Director		216-28-5509	1 🗆 N	2 √2 F		89	Yrs.	WORKER	Days	Tiours	Witti.	Feb. 20	19	15		land	
	D		Usual Residence of Decedent															
	how =		10a. State 10b. County			10c.	City, Tow	n or Loca	ation							1	Od. Inside C	•
	Ma Life	흥	Maryland Baltin	nore			Car	tons	vil.	le							I LJ Tes	s 2XC No
	# 128 #	Director	10e. Street end Number						10f. Z	ip Code				10g. C	itizen of V	Vhat Cour	try?	
	h wii		5464 Addington	Poad	1					21229	9			Uni	ted	State	2S	
	deat	Funerai	11. Merital Status	12.	Was Dec	cedent Ever in	U,S.	13. W				gin? (Sp	ecify Yes or No Rican, etc.)		14. Race	e - Americ	an Indian,	
0	after or its		1 Never Married 2 Marr	ied		2 XNo				2 No			, , , , , , , , , ,		Specify		nite	
8	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	þ	3 Widowed 4 Divorced		Year or I				_ 100	23,10	орослу.				Эрвену	. 441		
2	72 h	Completed	15. Decedent (Specify only highes	's Educat	ion ompleted)	16a.	Decede	ent's Us	ual Occupork done	oation during mos	t of work	king	16b. l	Kind of Bu	siness/Ind	lustry	
7	within ene.	횰	Elementary/Secondary (0-12)	1		(1-4or 5+)		life. Do	O NOT	use retire	d)							
7	filed wi Hygien fther th	ទូ	9				S	ales	Cle	erk	,			1	lighs		<u>-y</u>	
n	al Hygis I other	Be	17. Father's Neme (First, Middle,	Last)							18. Mothe	er's Nam	e (First, Middle	, Maide	n Surnam	Θ)		
/la	should be and Mental marked o	2	Walter Henry Ma	arric	ott								Childs					
lan	gas 1 end 2 should be filed within it of Health and Mental Hygiene. If Item 27 Is marked other than or other traumatic event, the Merical Control of the control of the Merical Control	1	19a. Informant's Name/Relations	hip <i>(Type</i>	, Print)		19b	. Mailing	Addre	ss (Stree	and Numb	er or Rui	rel Route Numb	er, City	or Town,	State, Zip	Code)	
Σ	1 end 2 Health em 27 I		Nick McCubbin/	Son			10	36 H	idd	en Mo	oss Dr	ive,	Hunt Va)30
Ze	of Hei	-1	20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation	2 🗆 🗆 🗆	a val fram	20b	. Place o	f Disposi ry, crema	ition <i>(N</i> atory or	ame of other pla	сө)		Date		Location -			
E	Pagas nant of h int: if ite		4 □ Donation 5 □ Other (S)		iovai iroii	E	verg	reen	Me	n. G	ardens	3 1	2/24/04	Fir	ıksbu	rg,Ma	ırylar	ıd
Baltimore, Maryland 21215-0020	프로로	- 1	21. Signature of Funeral Service	Licensee		-		22.	Name	and Addre	ess of Facili	y Hul	obard F	uner	al H	ome,	Inc.	
ä	Departimbo	- 4						41	07 1	Wilke	ens Av	<i>r</i> enue	e,Baltin	nore	≥. Ma	rvlai	nd 212	229
		\dashv	23a. Part1. Enter the diseese, or shock, or heart failure. List	complica	tions that	caused the de	eath. Do	not enter	r the mo	de of dy	ng, such as	cardiac	or respiratory a	rrest,	7		Approxima	ate
4	Physician		shock, or heart failure. List	only one	cause on	eech line.										i	Interval Be Onset and	Death
8	/Medical		Immediate Cause (Final		V	neu	100 6		,							į		
赋	Examiner		disease or condition resulting in deeth)	a	1					Ν.								
		ě				Due to	o (or as a	consequ	ience o	<i>)</i> .						l i		
	uted ansit	Examiner		b		Due to	o (or es a	consequ	ence of	· · · · · · · · · · · · · · · · · · ·								
	axec n end iel-tra	Ä	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury			000 10) (OI 03 a	oonsoqu	101100 01	/-								
68760,			that initiated events	C		Due to	(orasa	conseque	ence of	١٠								
89	ficat phy s th	//Medicai	resulting in death) Last			D 00 to	(0) 43 4	oor racqu	01100 01	,.								
Box		⋛│		d							-					i		
ă	ras thet tha daath signed by tha atter I be detached for u	Physician	Part II. Other significant condition	ne contril	buting to	death but not a	resulting i	n the un	derlying	cause di	ven in Part		23b Did	tobecc	o use cor	atribute to	the cause	of death?
P.O.	tha d	nys	rattii. Other significant conditio	ara contra	buting to t	Jean Dut not i	i bauting i	ir tile dile	derrynig	cause g	VOI7 111 7 GIT	•					bably 4	
	thet	<u>~</u>															,	
ds.	uiras n sigr Ild be	d b											24a. Was		opsy		ere autopsy	
õ	v requira been sig	ete											pend	ormed?		co	ailable prior mpletion of death?	cause
Re	e law has	Completed											10	v	2 0 No	100	Yes 2	746
a	iclan: The k certificate ha rector, page	ပိ	or Manager and to madical								00 81	(D					1103 212	3740
₹	iclar centif recto	0	25. Was case referred to medical examiner?	-	pital:	11			•	Ot Ot	hor:		th (Check only		0 004			
of	Physic this c	2	1 Yes 2 No		28e. Date	Inpatient 2	T .	Time of	3 🗆 [28c. Inju	4 (3-14)	ursing H	ome 5 Resi				0	
5	ding I h. After funar	틸	1 □Natural 5 □ Pendin	g	(Mo	nth, Day Year		Injury	м	Wo	ink?]Yes 2.⊟	No		,	,			
Si	Attending Physician: The law requiras thet tha daath or daath. ctor: Atter this certificate has been signed by tha atter by the funeral director, page 2 should be detached for by the funeral director, page 2.	Cal	3 Suicide 6 □ Could i	not be	28e Plec	e of Injury - A	t home fa	arm stre					28f. Location (Street a	and Numb	er or Rura	l Route Nur	mber,
Division of Vital Records,	5 # 5 E	Certification:	4 ☐ Homicide determ	inea		ding, etc. (Spe		21111, 3410	ot, raote	,, ooo			City or To					
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyin	g Physic	ian: To th	e hest of my l	nowledos	deeth -	occurre	d at the ti	me, date ar	nd place	and due to the	Ceuse/	s) and m=	nner as s	ated.	
	To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical one)	Examine	: On the	basis of exam	ination an	d/or inve	estigation	n, in my	opinion, dea	th occur	red et the time,	date ar	nd place,	and due to	the cause(s)
	ithin (Me l	29b. Signature end title of certifie	اد ۲					2	9c. Licen	se number			29d. D	ate signe	d (Month,	Day, Year)	
	8 ₹ ₹ ₹		· Co	1		0	D	.0		400	544	24	(2	- 22	0	4	
	1			4	-													
	り		30. Name end eddress of person	who com	pleted cau	use of death (I	tem 23e)	(Type, P	rint)	Dr	TOU	J 50	n. Mi) :	212	04		
			31. Dete filed (Month, Day, Year)			Registrer's Sig			A									
	Stat		51. Dete filed (Month, Day, 1991)	A	SE.	. logistion o oil	6	light	DOR	12/								

State of Maryland / Department of Health and Mental Hygiene 2004 05765 Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) FÉBRUARY 17, 2004 **Physician** 6:50 P M MOGUL SARAH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PIKESVILLE BALTIMORE MANOR CARE RUXTON If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 0CT.10,1917 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 👿 F 212-01-6083 86 Yrs TEXAS Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic svent, the Mudical Exemptor. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b County 1 ☐ Yes 2 ☑ No BALTIMORE Director BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21209 U.S.A. 2405 BARE ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Black White etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify: Specify: δ 3 ₩ Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **TAVERN** OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HAWTOF DORA GLICKMAN JOSEPH 3 1 2 1 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 660 STRAFFAN DRIVE #102 - TIMONIUM, MD 21093 WILLIAM HAWTOF / 20b. Place of Disposition (Name of cemetery, crematory or other place)

PARK 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OHEB SHALOM MEMORIAL 2/22/2004 REISTERSTOWN, MD 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 LAGATERAL. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ischemic Cardion Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 mopths? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 No 2 No 1 Yes Hospital or Attending Physiclan: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Diractor: filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-12849 Co lolly 3 Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER Dr. TOWSON MD 21204 GHILADI 32: Registrar's Signature 31. Date filed (Month, Day, Year) State 2 4 2004 FEB Registrar

			1 For State Registrar	State of	Marylan	d / Depa <i>Cei</i>	rtment of F	lealth and Death	Mental Hy	rgiene Reg. No. 200	4 05766
	Physici /Medio		Decedent's Name (First, Middle, Last Charles Mitchell	st)					2. Date of Do Month	Day Yes	3. Time of Death
	Examin		4a. Facility Name (If not institution, give St. Aanes		11	0	4b. City, Town, o	r Location of Dea		4c. County of D	
	Funeral Director		5. Social Security Number 6. S 212–16–0493	ex 7.	Age (In yrs. 1		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Di		Birthplace (State or Foreign Country) Maryland
Ø	should be filed within 72 hours after death with the Maryland of Menial Hygiene. I marked other than "natural", or flems 23a or 28a-f show umalic event, the Medical Examinational be motified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltime 10e. Street and Number 4706 Washington I 11. Marital Status 1 \(\text{Never Married} \) 2 \(\text{Married} \) Married	Boulevaro	nt Ever in U.	1	10f. Zip Code 21227 Vas Decedent of H Yes, specify Cuba		Specify Yes or Norto Rican, etc.)	10g. Citizen of What United Sta	10d. Inside City Limits 1 □ Yes 2 ☑ No Country? ates merican Indian, hite, etc.
Maryland 21215-0036	within 72 hours af ne. then "natural", or a Medical Exam	Completed by	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	If Yes, Give Year or Date ucation	s:	16a. Deced (Give i life. L	ent's Usual Occup. Sind of work done of NOT use retired	Specify: ation during most of wo	orking	Specify:	White
yland 2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the M	To Be Co	12 17. Father's Name (First, Middle, Last) James A. Magness)		Su	pervisor		nme (First, Middle	Aircraft Maiden Sumame)	-
ore, Mar	s 1 and 2 if Health a Item 27 lg other trai		19a. Informant's Name/Relationship (7 Eileen Dorothy Ma 20a. Method of Disposition	igness -	20b. PI	4706		on Boule		er, City or Town, State alethorpe, 20c. Location - City (MD 21227
Baltimore,	permit. Page Department of Important: If sny injury or once.		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify 21. Signatur of Funeral Service Licen)		idon Pa	rk Cemete Name and Addres	ery 2/2	ıbbard Fu	Faltimore, uneral Home more, Mary	, Inc.
8760,	cate be physicia the bur	dical Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or ab. Due to (or ac.	ed the death in line. OS () as a consequence as a conse	Do not ente	r the mode of dying	g, such as cardia	c or respiratory a	distract	Approximate Interval Between Onset and Death
.O. Box 6	that the death certific led by the attending p detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal at time of de	death 3 □E	Ectopic pregnancy Other (specify)			23d. Date of di Month	elivery Day Year
SS, Charles of Vital Records, P	aw requires that as been signed to 2 should be deta	Completed by PI	Part II. Other significant conditions co	intributing to death	but not resul	Iting in the und	derlying cause give	n in Part I.			to the cause of death? Probably 4 Unknown
Che lital Re		Be Com	25. Was case referred to medical examiner?					26. Place of Dea	autop	sy prior to death? 2 No 1 Ye	completion of cause of
agness,	ling Phys	Certification; To	1 Yes No 27. Manner of Death Natural	1 _ Inpa 28a. Date of In (Month, D	jury Pay Year) njury - At hon	R/Outpatient 8b. Time of Injury	3 DOA Othe 28c. Injury Work M 1 TY	r: 4 🗌 Nursing H	lome 5 Resid	lence 6 Other (Speciow injury occurred	
May A DIÑ	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Certi	29a. Certifier (Check only 2 Medical Exami	sician: To the bes	atc. (Specify)	ledge death	occurred at the time	e, date and place	City or Tow	ause(s) and manner a	
		Med	29b. Signature and title of certifier	Our	dy	MD	29c. License			29d. Date signed (Mon	
A)	Stat Registra		30. Name and address of person who co	Source	death (Item a	STA	int)	Healt	heare	Balt:	more

				State of Maryland	/ Department of He	alth and Me	ental Hygiene	COOO!	05767
		•	1 - State Registrar		Certificate of D	eath	Reg. No		05767
	Physicia /Medic		1. Decedent's Name (First, Middle, La Mildred E	E. Neal			2. Date of Death Month Day February	20, 2004	3. Time of Death 9:55 A.M
100	Examin	er '	4a. Facility Name (If not institution, give Stella Maris	e street and number)	4b. City, Town, or Li	ocation of Death	\$c.	Balk ma	re Co.
1	Funeral Director		011000000	To Age (In yrs. last	st birthday) If Under 1 Year		8. Date of Birth (Month, Day, Year) Jan 15, 19	9. Birthpla Countr	ice (State or Foreign
	Maryland I-f ahow	tor	Usuel Residence of Decedent 10a. State 10b. County Mary and CeC	(Co. 10c. City.	Town or Location			100	d. Inside City Limits
	th with the 23s or 28s	ai Director	10e. Street and Number 17B Northe	ast Isles D	rive 101. Zip Code 219	101	10g. Cit	izen of What Countr	y? A.
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland naturent of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23s or 28s-f ahow injury or other traumatic event, its Medical Examinar must be neitlied at injury or other traumatic event, its Medical Examinar must be neitlied at 8.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban,	oanic Origin? (Spec Mexican, Puerto P Specify:	cify Yes or No- lican, etc.)	14. Race - America Black, White, et Specify: White	
21215-0036	within 72 ho ene. than "natur te Medicel	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during DO NOT use retired)	on ring most of workin	g	ind of Business/Indu	. /
Maryland 2	should be filed ind Mental Hygi s merkad other umatic evant, II	To Be Co	17. Father's Name (First, Middle, Last,	H-111		8. Mother's Name	(First, Middle, Maiden	Sumame)	rknewn
	1 and 2 sho Health and Iom 27 is m		19a. Informant's Name/Relationship (M/S, Mildred) 20a. Method of Disposition	Cain (Day)	19b. Mailing Address (Street and 17 B) North (ce of Disposition (Name of	east I	sles Dr.	Northea Northea pocation - City or Tow	st, MD,
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once.		Burial 2 Cremation 3 Domain 5 Domain 5 Domain 5 Domain 5 Domain 21. Signature of Funeral Service Lice	Removal from State Lou	netary, crematory or other place) AON FACE CV 22. Name and Address	n. Feb. z.	3,2004 6	Boltimor	e, MD.
Ba	permit. Depart Import any inj		1 Jeffry of	gan, Sr.	feaceta 1	CK RO	fives fund	nium, H	10,21093
	Physician /Medical		23a. Pádri. Bhteir the dusease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	ivations that caused the death. he cause on each line. aALZHETMERS_D Due to (or as a conseque	ISEASE	such as cardiac or	respiratory arrest,	()	Approximate nterval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injuried events.	b. Due to (or as a conseque	ince of):				
3760,	ate be executed sysician and he burial-transit	cal	that initiated events resulting in death) Last	Due to (or as a conseque	ance of):				
P.O. Box 68	that the death certificate od by the attending phy detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of deal 9 Unknown	leath 3 Ectopic pregnancy			23d. Date of delivery Month D	v Day Year
	e law requires that the has been signed by th ye 2 should be detache	by	Part II. Other significant conditions of	contributing to death but not result	ing in the underlying cause given	in Part I.	23e. Did tobacco t	use contribute to the	cause of death?
Division of Vital Records,	The law ate has t page 2 s	Completed					24a. Was an autopsy performed?	prior to comi	sy findings available pletion of cause of
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	26. Place of Death			
ō	Phys ar this eral dii	n: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Injury 2	28b. Time of 28c. Injury a	4 Nursing Hom	e 5 Residence 8d. Describe how injure		
ion	Attending ir death. ector: Atter by the fune	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio			s 2 No			
Divis	2 # 2 0	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify)	ne, farm, street, factory, office		8f. Location (Street ar City or Town, State)	
	e Hospitel 24 hours a a Funeral D letely filled i	edical	29a. Certifier 1X Certifying Pl (Check only 2 Medical Exer	miner: On the best of my know and manner stated.	ledge, death occurred at the time on and/or investigation, in my opin	, date and place, a nion, death occurre	nd due to the cause(s) d at the time, date and	and manner as stated place, and due to t	red. he cause(s)
)	1	Me	29b. Signature and title of certifier)1	29c. License r	372S		te signed (Month, D.	ay, Year)
	Ŋ		30. Name and address of person who	124					
	Sta		DR. TARIO MAHMO 31. Date filed (Month, Date 2)	OD 2300 DULANE 4 2004 Register Sonat	Y VALLEY RD T	IMONIUM,	MD 21093		
	Pegist	202	4 40-4		*				

9:55 a.m.

FEBRUARY 20, 2004

MILDRED NEAL

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		•	1 - For State Registrar	State of Maryland / Depa	artment of Health and Martificate of Death	Mental Hygie	ene 2004	05768
	Physici	20	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		John D. O'Neill,			February	23, 2004	9:30 AM
	Examin	er	4a. Facility Name (If not institution, give :		4b. City, Town, or Location of Death		4c. County of Death	
	8		2525 Pot Spring R 5, Social Security Number 6. Sep		Timonium If Under 1 Year If Under 24 Hrs.	R Date of Birth	Baltimo	DIE place (State or Foreign
	Funeral Director			M 2□F 88 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 3. 500 2. 1915 1	Marvland
			Usual Residence of Decedent			000. 12	, 121P 1	idi yidi id
	nylan how		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Ba-f a	ç	MD Baltimor	e Timonium				1 ☐ Yes 2 ☒ No
	or 2	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cou	
	e 23a	La l	2525 Pot Spring R		21 093		United St	
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Iteme 23a or 28a-f show atto event, the Medical Exambra must be mailied at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puert	Rican, etc.)	14. Race - Amer Black, White	
36	af', or	Ď	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 □ Yes 2 □XNo Specify:		Specify:	White
21215-0036	2 hor	Completed	15. Decedent's Edu	cation 16a. Dece	dent's Usual Occupation	16	b. Kind of Business/l	ndustry
21.5	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of world DO NOT use retired)	king		
2	ygien ygien ver th	S	12	+ Pre	sident		Lion Brot	hers
ind	be fill d oth	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	iden Sumame)	
Z	ould Men varke	ပ္	Howard Dennis O'		Ernest			
Maryland	12 st h and 7 ts n traun	1	19a. Informant's Name/Relationship (Ty		ng Address (Street and Number or Ru			
	1 end Healt em 2		Carol Shear/daugh	20b. Place of Dispo	iderwood Station,		Marytand Oc. Location - City or 1	21 204 Town, State
JO.	nt of nt of t: # it		1 🔀 Burial 2 □ Cremation 3 □ R		natory`or other place) 02/9 Valley Mem. Grans	28/04		Maryland
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune 2 Service Lice	2//		1. T		
B	Depa Impo any ir		Suple OG	Coster 1	350 York Road Tow	son, Mary	land 21204	Home, Inc.
jo.			shock, of heart failure. List only or	ications that caused the death. Do not ent ne cause on each line.	er the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	LUNG	4RCINOM/4			MONTHS
H	/Medical Examiner			Due to (or as a consequence of):				(- (-) -)
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
ó	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a consequence of):				
38760,	cale be executed physician and the burial-transit	dical		d				
•	E O a	Ψ.	IF FEMALE:	OTTO				
Вох	death certifii e attending p ed for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of deliv	ery Day Year
0	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)			50,
<u>α</u>	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	P.	Part II. Other significant conditions cor	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Vital Records,	uires tha signed l	d by		•		1 ☐ Yes	2 No 3 Pro	bably 4 Unknown
COL	w requir been si should	lete				24a. Was an	24h Were aut	opsy findings available
Be	he lav e has ige 2	Completed				autopsy	prior to co	ompletion of cause of
ta		0	25. Was case referred to medical		26 Place of Dea	1 ☐ Yes 2 ☐ th (Check only one)	No 1 □ Yes	2 □ No
>		To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Other		ce 6 □Other (Spec	fv1
0	g Phys er this eral di		27. Manner of Death	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work?	28d. Describe how		97
Ö	Attending I ir death. ector: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(WORLD, Day 1 621) Injury	M 1 Yes 2 No			
Division of	of or Attend after death Director: A	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town,	et and Number or Rui State)	al Route Number,
Ω	spitel o		29a. Certifier Certifying Phys	sician: To the best of my knowledge, death	occurred at the time, date and place	and due to the cau	sa(s) and manner as	Printed
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examile one)	ner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)
	Vith To	2	29b. Signature and title of certifier	1.1/2/11	29c. License number	290	Date signed (Month)	Day, Year)
r	20		1 juli	WULL	D5482	2	123/0	' (
	10		30. Name and address of person who co	in C (AAD) 74()	1 OSUGR DRIVE	SVITE !	202 tou	(CAN MO)
i	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature			100	11234
	Registi	ar	FEB 2 4 20	MA Danie H	hour B			(

ORIGINAL

e u		For State Registrar 1. Decedent's Name (First, Middle, La:	State of Mar	ylanu / De	epartifica Certifica	te of l	Death		2. Date of Dea	ith		0576
Physiciar /Medica		SID	NEY		0SE	ROFF		r	. Month Eburary	Day 18	Zooy	12:58pm
Examine	4	a. Facility Name (If not institution, given UNION MEMORIAL			4b. City	, Town, or	Location of	Death	PF /	4c. Coun	ty of Death	N/A
Funeral	5	5. Social Security Number 6. S	ex 7. Age	(In yrs. last birtho	(ay) If Undo	r 1 Year Days	If Under 2	4 Hrs.	R Date of Birth	Yearl	9. Birthp	lace (State or Foreign
Director	-	214-16-8973 Jsual Residence of Decedent	X M 2□F	82 Yr	S. Months	Days	Hours	IVIIII.	0CT.19	,1921	Court	MD MD
yland	-	10a. State 10b. County		10c. City, Town o	r Location						10	Od. Inside City Limits
Ba-fa	2	MD N/A		В	ALTIMO							1 ¥ Yes 2 □ No
after death with the Ma in items 23a or 28a-fa unetter matter reliffer	5 1	10e. Street and Number 2903 FALLSTAFF R	ΛΔD #205		10f. Z	ip Code	212	na	1	10g. Citizen o	f What Coun	U.S.A.
death	1	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Dec	edent of Hi			ify Yes or No-		ace - America	an Indian,
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumette event, the Modical Examinate matter neithed at once.	n y	1 Never Married 2 Married 3 M Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:	WWII	1 🗆 Yes		Specify:		, ,	Spec		WHITE
72 hou natura		15. Decedent's Ed (Specify only highest gra	ducation	16a. D	ecedent's Us	ual Occupa	ation	of working	7	16b. Kind of	Business/Inc	dustry
within ane. Ihan	Completed	Elementary/Secondary (0-12)	College (1-4or 5+))	RIVE KIND OF WIND NOT ANAGER	use retired)	or tronting		CLOTHI	NG MAI	NUFACTURIN
a filed ii Hygi other	ນ 1	17. Father's Name (First, Middle, Last)		1 1.1	MAGEN		18. Mother	's Name (First, Middle,			NOT ACTORIN
Mental Mental Marked Marked	2	NATHAN			SER0FF		LEN					ERSH0FSKY
d 2 sh lth and 27 io m traum		19a. Informant's Name/Relationship (NORMAN OSEROFF	** *						Route Numbel BALTIM	-		
ss 1 an of Heal item 2	12	20a. Method of Disposition		20b. Place of D cemetery,						20c. Location		
permil. Page: Department of mportent: If i nny injury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	y)	JWV MD	FREE S	TATE	POST					
permit Depart Import any in		21. Signature of Funeral Service Licer	300	i,			s of Facility		L LEVIN			, INC. MD 21208
SALES OF		23a. Part1. Enter the dis / se, or c/m shock, or heart fail re. List only	/ plications that caused the	ne death. Do not	The second second	-		-			16669	Approximate Interval Between
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/Medical Examiner		resulting in death)	Due to (or as a	consequence of)						-		75
\$2 B	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying	b. Due to (or as a	consequence of)								
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w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	laiv.	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	Fetal death	3 Ectopic 5 Other (s						ate of deliver	ry Day Year
The law requires that the death ate has been signed by the atter page 2 should be detached for u	32	1 Yes 2 No 9 Unknown	9 Unknown	nie or death	5 Li Other (s	рөсну/						
es tha igned l	ر د د	Part II. Other significant conditions of	ontributing to death but	not resulting in th	e underlying	cause give	n in Part I.					e cause of death?
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e la has							-		24a. Was a autops perform	ned?	prior to con death?	osy findings available inpletion of cause of
	ט _	25. Was case referred to medical examiner?					26. Place	of Death (1 □ Yes : Check only on	2 2 No	1 ☐ Yes	2 2 N o
this aldi	2	1 Yes 2 No	Hospital: 1 Inpatient	-			4 Nurs		→ 5 Reside)
i or Attending F after death. Director: After I in by the funera		27. Manner Teath 1 Utural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	Year) 28b. Tim Inju	e or ry M	28c. Injury Work	rat ⟨? Yes 2.∐N		d. Describe ho	ow injury occu	rred	
r Atter er dea rector by the		3 Suicide 6 Could not be determined		y - At home, farm (Specify)	, street, facto	ry, office		28	f. Location (St City or Town	reet and Num	ber or Rural	Route Number,
pital o	ر د	On Continu										
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	מבו בי	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysicien: To the best of niner: On the basis of e and manner state	xamination and/o	r investigatio	n, in my op	ie, date and pinion, death	piace, an occurred	a due to the ca at the time, d	ause(s) and π ate and place	anner as sta , and due to	ated. the cause(s)
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Joseph RJD	Prima	veı	State of Maryland / Department of Health and 1- State Registrar Certificate of Death	Mental Hy	giene 2 (004	05770
4	Physici		Decedent's Name (First, Middle, Last) Joseph Angelo Primavera	2. Date of De		2004	3. Time of Death 0422A
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	ath		ry of Death	1
	Funeral Director	**	University Hospital 5. Social Security Number 6. Sex 1 M M 2□ F 7. Age (In yrs. last birthday) 1 Vrs. 7. Age (In yrs. last birthday) 1 Vrs. 1 Months Days Hours Mi	n. (Month, Da	th.	9. Birthp	ilace (State or Foreign htry) sylvania
	death with the Maryland rma 23a or 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10g. Citizen of		0d. Inside City Limits 1 ☐ Yes 2 🎇 No
	urs after death with al', or Itema 23a or Fram his must be	by Funerai	4302 Old Farm Road 11. Marital Status 1 □ Never Married 2 ☑ Marned 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Specify: 1 □ Yes 2 ☑ No Specify: 1 □ Yes 2 ☑ No Specify:	(Specify Yes or No erto Rican, etc.)	USA 14. Ra Bla Speci	ce - Americ ack, White,	etc.
Baltimore, Maryland 21215-0036	be filed within 72 hours after ital Hygiene. Id other then "natural", or Ite event, the Medical Examine	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) Owner/Proprietor	rorking	16b. Kind of E		Station
yland	is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Meres and the Meres are seen to th	To Be	Ralph Primavera Josep		Ver	na	
re, Maı	Health and tem 1 Health and tem 27 is nother traun		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Name) Marlyn F. Peterson/Sister-in-law 205 Frazier Court, 20a. Method of Disposition 20b. Place of Disposition (Name of	Joppa,		d 210	085
altimo	permit. Pages Department of Important: If it any injury or o		'4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem. Grdns 21. Signature of Funeral Service bicenses / 22. Name and Address of Facility		Timoni	um, Ma	aryland
ä	Per ing		Dryan W. Clary Lemmon Funeral Ho 10 W. Padonia Roa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or head failure. List only one cause on each line.	d, Timon	ium, MD	alley 210	Inc. 93 Approximate Interval Between
	Physician (Medical Medical System and Medical Examiner Itansit the prinaritiansit of the prinarity of	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of):	ethons			Onset and Death
$\stackrel{ alpha}{\sim}$ Division of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certificate be executed ricidath. ector: Atter this certificate has been signed by the attending physician and by the tuneral director, page 2 should be detached for use as the burial-transity.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown			ate of delive	ry Day Year
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Ž.	Physician: this certific al director,	To B	examiner?	eath (Check only only only only only only only only		ner (Specify	·)
ision o	Attending Ph death. ctor: After th y the funeral	Certification:	27. Manner of Death 1 Natural 2 Natural 2 Natural 3 Suicide 3 Suicide 4 Deminde 4 Deminde 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28c. Injury at Work? vehid	how injury occur L D ULE Street and Numi	led "	with thee	
₩ å	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	cal Certi	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.	Jarrettsu.	on, State) Le Pyce Lit	Blent	eim Road.
	To the H within 24 To the F complete	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occard and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signe	ed (Month, L	Day, Year)
	gxi		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Stree	t, Baltin	_		
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
DHM	/H 17 Rev 1/2	001	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 21 2004 Joseph Frank Papa **Physician** 1421 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Westminster Carrol1 tf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Oct 15 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 88 215-01-4393 Md Director Usuel Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. tnside City Limits Department of Health and Mental Hygiene, instructly, or Itama 23e or 28e-f show important: if item 27 is marked other than "natural", or Itama 23e or 28e-f show any injury or other traumatic event, the Modical Examinat must be notified at ence to process. Md Howard 1 ☐ Yes 2 No Ellicott City Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 11860 Triadelphia Road 21042 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specifywhite 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) foods produce worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Vincent Papa Concetta Barranco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11860 Triadelphia Rd., Ellicott City, Md 21042 Samuel V. Papa (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ♥ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Crest Lawn Memorial Marriottsville. Md 2-24-04 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Page Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** ASPIRATTON WEE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit The law requires that the death certificate be executed CONGESTIVE that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien for use as the buria Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed 1 Yes 2 No Hospital or Attending Physician: neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No s after death. death. investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral C completely filled i 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) na 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER, MI DR TRINA 120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 4 2004 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
Louise S. Phillips 2. Date of Death 3. Time of Death ^{Day} 21 2004 **Physician** 6:55am February /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carrol1 Long View Nursing Home Manchester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 22 1901 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 213-09-7459 103 Jan Director Md Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location other than "natural", or items 23a or 28a-f show vent, the Medical Examinar must be notified at 10d. Inside City Limits Md Carrol1 Manchester 1 TYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3332 Main Street 21102 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes Give X 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 ð Yes, Give 1 ☐ Yes 21 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) communications Hygiene. telephone operator permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William F. Schrage Marie R. Schneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Charnock (executor) 5866 Mineral Hill Rd., Sykesville, Md 21784 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State New Oakland Cemetery 2-27-04 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, Md * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel ponce + Varge Haight Sterburt P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myscarst disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner ASCVD Facuarity is conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine been signed by the attending physician and should be detached for use as the burial-transit death certificate be executed advonce resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death P.O. 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 内 Nursing Home 5 日 Residence 6 日 Other (Specify) Hospital: 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) In W. Mitalleton InD D25443 n 30. Nam and address of person who completed cause of death (Item 23a) (Type, Print) 4 2004 Registrar's Signature Road Westminster, MD 21157 State Registrar

			S	tate of Maryland	/ Departmer	it of Health and	Mental Hygi	ene and	05770
			State Registrar			e of Death	Re	g. No. 2004	05//3
	Physicia /Medio	an	1. Decedent's Name (First, Middle, Last) ARIAN	C	POOL	E	2. Date of Death Month FEBRVAR	21, 2004	3. Time of Death
	Examin		4a. Facility Name (If not institution, give stre		4b. City	Town, or Location of Dea	NIE	4c. County of Death ANNE AR	UNDEL.
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last		r 1 Year If Under 24 Hrs	8. Date of Birth	Year) 9. Birthpla	ace (State or Foreign ry) NSYLVANIA
	yland		Usual Residence of Decedent 10a. State 10b. County		Town or Location			10	od. Inside City Limits 1 ☐ Yes 2 ★ No
	the Mar 28a-1 s	Director	MARYLAND ANNE ARUN 10e. Street and Number	DEL GU		UIE p Code	10	g. Citizen of What Count	
	23a or	rai Di	1127 WYNBROOK			1060		USA	n Indian
36	hours after death with the Maryland turst', or ttems 23s or 28s-f show al Execution must be rediffed at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:	. 13. Was Dece If Yes, spe 1 ☐ Yes	dent of Hispanic Origin? (softy Cuban, Mexican, Puer 2 No. Specify:	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e	
15-0036	72 hours •natural,	Completed	15. Decedent's Educati (Specify only highest grade co	on ompleted)	16a. Decedent's Usu (Give kind of w	ial Occupation ork done during most of wo use retired)	orking 1	6b. Kind of Business/Ind	ustry
2121	d within giene. or than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	11	VAKER		AT HOM	E
Maryland	ges 1 and 2 should be filed within 72 hc at of Health and Mental Pygiene. If item 27 is marked other than 'natur or other traumatic event, the Madical	To Be C	17. Father's Name (First, Middle, Last) PAUL CARL	N		MA	me (First, Middle, M RIE W	HITE	
Many	d 2 sho Ith and I		19a. Informant's Name/Relationship (Type,	Print) DAVGHTE		s (Street and Number or F		City or Town, State, Zip	
	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or othar tr once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Pla cer	ace of Disposition (Nametery, crematory or	me of other place)	Date 2	Oc. Location - City or To	
Baltimore,	Pa mer mer jury		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		HAPEL-	BELAIR FER	, 23, 2004 FACEFUL AL	TERNATIVES	FUNGRAL
Ba	Depart Import any in		E	39	- AND C	REMATION CEN	TER. 2325	YORK RO. TO	
-	Physician		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final disease or condition	cause on each line.	LOW O L O	de or dying, such as cardia	COTTESPHATORY ATTE	51,	Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or a conseque	ency of):	رو در در در در در در در در در در در در در	n	-	2 week
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3760	ate be e hysician the buria	cai	d						
Box 68	The law requires that the death certificate be exite has been signed by the attending physician page 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnan	death 3 Ectopic		Wilder	23d. Date of deliver	ry Day Year
P.O. I	that the de ed by the a detached t	hysic	1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at time of dea 9□ Unknown	ath 5 ☐ Other (s	респу)	1		
	w requires that been signed should be det	ρ	Part II. Other significant conditions contri	buting to death but not resul	ting in the underlying	cause given in Part I.	23e. Did tob	accoluse contile to th s 2 o 3 ☐ Proba	e cause of death?
Division of Vital Records,	The law re ate has bee page 2 sho	Completed					24a. Was ar autops perform 1 Yes 2	prior to con death?	osy findings available inpletion of cause of
ital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				ath (Check only one		
of V	this aldi	2	1 ☐ Yes 2 ☑ No Hos 27. Mann f Death	28a. Date of Injury	FVOutpatient 3☐ D 28b. Time of	OA Other: Nursing 28c. Injury at Work?	Home 5 Reside	nce 6 Other (Specify w injury occurred)
sion	tanding leath.	catlo	1 Atural 5 Pending 2 Accident investigation 3 Suicide 6 Could not se	(Month, Day Year)	Injury M	1 ☐ Yes 2 ☐ No	29f Location (Ct	eet and Number or Rura	I Route Number
Divi	al or At s after d il Diract id in by	Sertifi	4 Homicide determs ed	 Place of Injury - At hor building, etc. (Specify) 		iry, oπice	City or Town		riodie rumber,
	To the Hospital or Attandii within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	Medical Certification;	29a. Certifier Certifying Physic (Check only one)	ian: To the best of my know r: On the basis of examinati and manner stated.	vledge, death occurre on and/or investigation	d at the time, date and place on, in my opinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner as state and place, and due to	ated. the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	in S. Fried	0.00 C 4.4 v. b. Z 1	9c. License number		9d. Date signed (Month, I	
	1		30. Name and address of person who com	pleted cause obteath from	23a) (Tune Print)	D2630	0,0,00	2/25/0	9
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	St Reg ist	ate rar	31. Date filed (Month, FEB 2 4 2	32. Registrar's Signati	ure M. Ana	ell o			

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	Physici /Medic		1. Decedent's Name (First, Middle, Last, Gary Lee Pinnell)				2. Date of Dea Month Februa	Day \	3. Time of Death Year 2004 2045 PM
	Examir	-0	4a. Facility Name (If not institution, give 4411 Leeds Avenu			4b. City, Town, o	or Location of Deatl	ז	4c. County of Balti	
	Funeral Director		5. Social Security Number 6. Se. 220–50–6980 Usual Residence of Decedent	7. Ag M 2□F	e (In yrs. last birthday 53 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Jun 5,	y, Year)	9. Birthplace (State or Foreign Country) Maryland
	th the Maryland or 28a-f ehow	Director	10a. State 10b. County MD N/A 10e. Street and Number		10c. City, Town or L		imore		10g. Citizen of Wh	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
920	n 72 hours after death with the Maryland "natural", or items 23s or 28s-f show edical Exami in minust be motified at	by Funeral	4411 Leeds Avenue 11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	No	Was Decedent of Hif Yes, specify Cub.	21229 dispanic Origin? (S an, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	United 14. Race- Black, Specify:	States American Indian, White, etc. White
Maryland 21215-0036	d within 72 piene. ir then "na	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12		(Give	dent's Usual Occup e kind of work done DO NOT use retire Laborer	during most of wor		16b. Kind of Busi Gen Maiden Sumame)	eral
aryland	O C D O	To Be	17. Father's Name (First, Middle, Last) Daniel B. Pinnell 19a. Informant's Name/Relationship (Ty	rρe, Print)	19b. Mail	ing Address (Street	Mild	red V. H	ickman	
Baltimore, Ma	and 2 lealth a m 27 is		Marsha Grimm Si 20a. Method of Disposition Burial 2 Cremation 3 F 4 Dongation 5 Other (Specify)	ster	20b. Place of Disp	matory or other plac	cθ)	Date	MD 2122 20c. Location - Ci Baltimo	ity or Town, State
Baltir	permit. Pages 1 Department of H Importent: if ite any injury or ot once.	(21. Signature of Funeral Servic Lice	april	U0/38/ 1	2. Name and Addre 328 Sulph	^{ss of Facilit} Amb ur Sprin	rose Fun g Rd., A	eral Homerbutus, l	e, Inc. MD 21227
	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ATHEVO!	ne.	rdiavascula			rest,	Approximate Interval Between Onset and Death
8760,	cate be executed by some properties of the burial-transit canal	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):					
O. Box 6	requires that the death certificate een signed by the attending physi hould be detached for use as the I	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Fetal death 3	Ectopic pregnancy	1		23d. Date of Month	
<u>α</u>	w requires that been signed by should be deta	by	Part II. Other significant conditions con	ntributing to death b	ut not resulting in the u	ınderlying cause gıv	en in Part I.			ute to the cause of death?
Vital Records,	The law ate has b page 2 sl	Completed						24a. Was a autop perfor	sy prio	ore autopsy findings available of to completion of cause of ath? Yes 2□ No
of	ding Physic h. After this co funeral dire	atlon: To Be	25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inpatie 28a. Date of Inju (Month, Da	ry 28b. Time o	of 28c. Injur Wor	er: 4 Nursing H		ne) ence 6 ⊡t©ther ow injury occurred	
Division	P afte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
	H H H	edical	(Check only 2 Medical Exami one)	sician: To the best ner: On the basis of and manner sta	of my knowledge, dear examination and/or in ited.	vestigation, in my o	pinion, death occu	rred at the time, o	late and place, and	d due to the cause(s)
	To the I within 2 To the I complet	Σ	29b. Signature and title of certifier	M.	The same of the sa	29c. Licens	e number C.M.E.		Pebruary	Month, Day, Year) 17, 2004
	\		30. Name and address of person who	likes, M	<u>)</u> 111	Penn Str	eet, Bal	timore,	Maryland	21201
	Sta Registi		31. Date filed (Month, Day, Year) FFR 2 4 2004	32. Registr	ar's Signature	porks				

			1- For Amend Item 10e per FH, G829, 03/05/04dhb Registrar Amend Item 23a, PtI per Dr., G829 Ce	artment of <i>rtificate o</i> i	Health and If Death 03/1	Mental Hyg 1/04dhb	giene 200	4 05775
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Dea		3. Time of Death
ı	/Media	cal	Wishit 4a. Facility Name (If not institution, give street and number)	,	Pate/ or Location of Death	Februar	y 17, 200	4 01:00 M
*	Examir	ier	The Johns Hopkins Hospital	Battim	ore Ci	fy	4c. County of De	
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 214-51-5097 Age (In yrs. last birthday) 36 Yrs.	Months Day		Jan. 25		irthplace (State or Foreign Country) 12ania
	yland		10a. State 10b. County 10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mar 3a-f st	ctor	Maryland Anne Arundel Laurel					1 ☐ Yes 2 ☑ No
	with the a or 21	Funeral Director	10e. Street and Number 3227 Orient Fish Tail Rd. 3627 Orient Fish Tail Road	10f. Zip Code 20724			10g. Citizen of What C	Country?
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of	Hispanic Origin? (St	ecify Yes or No-		
920	be filed within 72 hours after death with the Maryland nia! Hygiene. so other than "natural", or Items 23a or 28a-f show event, the Madical Examiner must be notified at	þ	1 Never Married 2 Married 1 ☐ Yes 2 M No	1 Yes, specify Cu 1 ☐ Yes 2017 No	ban, Mexican, Puèrto o <i>Specity:</i>	Hican, etc.)	Specify: As	_{site, etc.} sian Indian
21215-0036	n 72 ho "natur edical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occi kind of work don DO NOT use retir	e during most of work	ing	16b. Kind of Busines	s/Industry
212	e filed within at Hygiene. other than "	d Wo	Elementary/Secondary (0-12) College (1-4or 5+)		echnician		Neighborh	ood Pharmacy
	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nam		Maiden Sumame)	iood Tharmacy
Maryland	should by and Menta	ပို				gauri	Pate1	
Ma	s 1 and 2 should 1 Health and Mer Nem 27 is marks other traumatic		71				r, City or Town, State,	
ore,	ges 1 ar t of Hea if Item or othe		20a. Method of Disposition 1 Burial 2 1 Cremation 3 Removal from State	sition (Name of matory or other pl	ace)	Date La	20c. Location - City o	1and 20724 r Town, State
Baltimore,	Pag lent nt: I ry o	. ,	*4 Donation 5 Other (Specify) Balt/Wash.	. Cremat	ory 2/20	/2004	Laurel, M	aryland
Bal	permit. Pac Department Important: sny injury once.		Nal 1 (0)	Name and Addi 501 Sand	- F1	eck Fun	eral Home, aurel, Mar	Inc. vland20707
	4 -		23a. Part1. Enter*the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dy	ring, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Acute respiration Due to (or as a consequence of):	tory d.	istress .	syndion	10	17 days
	Examiner			Carini				17 days
	De iis	iner	if any, leading to immediate Due to (or as a con equence of):	Currin	phec	monia		6 months
•	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events c. Loue to (of s a consequence of the cons	phomo				18 months
58760,	ficate be executed physician and is the buriat-transit	dical	d					
_	entifica ling ph e as th		IF FEMALE:					
.O. Box	The law requires that the death certifica sie has been signed by the attending ph page 2 should be detached for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnand Other (specify) _	cy		23d. Date of de Month	livery Day Year
۵.	res that the de igned by the a be detached t	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause gr	iven in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
ords	w requires been sign should be	ted by				1 🗆 Ye	es 2 ≣ No 3∏P	robably 4 DUnknown
Records,	The law resete has be page 2 sh	Completed				24a. Was a autops perform	by prior to med? death?	utopsy findings available completion of cause of
/ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?		26. Place of Death			5 2 NO
of	hys his I dill	٦.	1 ☐ Yes 2 ♣ No Hospital: 1 ■ Inpatient 2 ☐ ER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of	t 3□ DOA Ot 28c. Inju			ence 6 Other (Spe	ecify)
ion	Attending r death. ector: After by the funer	atlon	1 ■ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Wo	ork? Yes 2 No	zsa. Describe no	ow injury occurred	
Division of Vital	of or Attending Phater death. I Director: After that in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	et, factory, office		28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospitel or within 24 hours at To the Funerel D completely filled it	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the trestigation, in my	ime, date and place, opinion, death occurr	and due to the ca	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. Licen	se number	29	9d. Date signed (Mont	h, Day, Year)
	- the		Vynette M Brown M.D., Ph.D.	RE	5 - 000	F	ebruary 1	7. 2004
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, I Lynette Brown Johns Hopkins Hospit			, 3	m	1 / >
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	2.	Wolf + 31/4	tt, Dalt.	imort, /llary	viand 21287
	Registr	ar	FER 2 4 2004 Same 19 10	mks/				

unpend Item#23a.27 FFR MF. 9831.5/13/(Veg Amend Item #1 per me 6831.5/13/04 Fast Indeed Ink. Ensure All Copies Are Legible.

			1 - For State Registrar		State	of Mary	land / De	epa C <i>er</i>	irtment of F tificate of	lealth <i>Death</i>	and Me		giene Reg. No	(05776
	Physici	an	1. Decedent's Name	(First, Middle, L	ast)	ъ.		_				2. Date of De Month	Da	y Year	3. Time of Death
	/Medic	cal	PRESTO 4a. Facility Name (If		OPF		n L. Pope	e Si	4b. City, Town, o	r Location		FEBRUA		8, 2004 County of Death	2220 P M
	Examir	ner	BAYVIEW	_		number)			BALTIMO				1	NA	
YE !	Funeral	, voice	5. Social Security No		Sex		yrs. last birth		If Under 1 Year Months Days			8. Date of Bir (Month, Da	th V. Year		plece (State or Foreign ntry)
	Director		216-46-9	134	1 X]M 2□F		57 ^{YI}	rs.	Months Days	110010		JULY 2	3, 1	946	NA
	land ow		Usual Residence of 10a. State	10b. County		10	c. City, Town	or Lo	cation						10d. Inside City Limits
	Marylan s-f show lifed at	tor	MD	N	Ά			BA	LTIMORE						1X Yes 2 No
	with the Marylan a or 28e-f show be notified at	Director	10e. Street and Num	nber					10f. Zip Code				10g. Ci	tizen of What Cou	ntry?
	death with the Maryland ms 23a or 28e-f show rmall be notified at			PARKSIDE			PT. C			21206				USA	
30	be filed within 72 hours after death w Ital Hygiene. Id other then "naturel", or Items 23e event, I'ra Medical Exercites must	by Funerai	11. Marital Status 1 Never Marrie 3 Widowed	ed 2 Married	Armed 1 ☐ Ye If Yes,	ecedent Ever Forces? es 2 XNo Give or Dates:	r in U.S.		Vas Decedent of H i Yes, specify Cuba □ Yes 2፟ No	dispanic Or an, Mexica Specity.		ify Yes or No ican, etc.)		14. Race - Ameri Black, White, Specify: AFR	etc. [CAN
2-0036	2 hou	ted	/0	15. Decedent's E	ducation		16a. C	eced	ent's Usual Occup	ation	A = 6		16b. K	AMI and of Business/Ir	ERICAN dustry
<u> </u>	thin 7	Completed	Elementary/Secon	fy only highest gi ndary (0-12)		e (1-4or 5+)		life. [OO NOT use retired	<i>duri</i> ng mos d)	st of working	9			
Z	led wi		10 17. Father's Name (First Middle I as	A1	0			DRIVER	10 14-15		(Final & 41 date)	14-7-4		COLA
and	ntal H	Be c	LOU:		()					18. MO(n		First, Middle,		Sumame)	
	2 should and Men Is marke eurnatic	2	19a. Informant's Na		(Type, Print)	-	19b. N	Mailin	g Address (Street	and Numb	LILL er or Rural			or Town, State, Zij	Code)
E	and 2 Baith a n 27 is		ELOUISE	SCOTT	(AUNT)		101	. 5	E. LAN	VALE	STRE	ET BA	LTIN	ORE MIN	21202
e,	_ + = -		20a. Method of Disp	osition Cremation 3 (□Removal fro	1	Ob. Place of D	Dispos	sition (Name of natory or other place		Da	te	20c. L	ORE MI ocation - City or To	own, State
Ĕ	Pag ment tant: I		`4 □Donation	5 ☐ Other (Spec	ity)	Sin State	MT. Z		N CEMETER		2/24/		LA	NSDOWNE.	MD
Saltimor	permit. Pages 1 Department of H Important: If ite eny injury or ot		21. Signature of Fur	neral Service Lice	m300		•	22	Name and Addres		· nı.			L HOME F	
			23a. Part 1. Enter th	e disease, or cor	nplications tha	at caused the	death. Do no	t ente	638 N. (ALTI rest.	MORE, MI	21217 Approximate
	Physician /Medical Examiner	Examiner	Immediate Cause (disease or condition resulting in death) Sequentially list conditions are supported to the cause. Enter Under Cause (Disease or that intitated events	nditions, indicate the trying niury	a. Hyp Due	ertensiv	we Athen):	lerotic Ca	rdiova	scular	Disease			Interval Between Onset and Death
68/60,	ificate be executed g physicien and as the burial-transit	edicai Exa	resulting in death) L	ast	c. Due	to (or as a co	onsequence of):							
O. Box 68	death certiff e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	1□Liv	outcome of p re birth 2 egnant at time	Fetal death		Ectopic pregnancy Other (specify)	,				23d. Date of delive Month	ery Day Year
cords, P	w requires that the been signed by th should be detache	by	Part II. Other signifi	cant conditions	contributing to	o death but no	ot resulting in t	he un	derlying cause give	en in Part I			obacco i		ne cause of death?
ž Ž	The law ate has b page 2 st	Completed										24a. Was autop perfo	sy	doath?	psy findings available mpletion of cause of
Vitai	ician: Th certificate rector, pag	Be	25. Was case referr examiner?	ed to medical	Hospital:				Oth			Check only o	ne)		
10	Physic rithis crail dir	5.	1 X Yes 2 ☐ 1 27. Manner of Death		11		2 ER/Outp	_		4 🗆 140		d. Describe h		6 ☐Other (Specif	y)
0	th. : After	tion	1 XNatural 2 ☐ Accident	5 Pending		ate of Injury fonth, Day Ye	ar) Inji		28c. Injun Worl	k? Yes 2 □		d. 2000/100 (10 11 11 11	y occurred .	
DIVISION	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	4 288. Pla	ace of Injury - ulding, etc. (S	At home, farm	n, stre	eet, factory, office		28	f. Location (5 City or Tox	Street an yn, State	d Number or Rura)	l Route Number,
	he Hospit in 24 hour he Funere pletely fille	edicai	29a. Certifier (Check only one)	1 ☐ Certifying P 2 ☑ Medical Exe	miner: On the	the best of me basis of exa nanner stated.	amination and/	death or inv	occurred at the tin estigation, in my of	ne, date ar pinion, dea	d place, an th occurred	d due to the o	cause(s) date and	and manner as s place, and due to	tated. the cause(s)
	with To t	Σ	29b. Signature and	title of certifier	. /	1			29c. License	e number OCM	E.			te signed (Month,	
			1h	coden	U. K	Cig.	-ug				T.		rre	BRUARY 20	2004
			30. Name and addre	ess of person who		. 1			Penn St	reet	Ral+	·m	M	arland 01	201
	Sta	ite	31. Date filed (Mont		32	. Registrar's					weat L.	TINTE,	HOLL	утана 21	201
	Registr		FFR	2 4 2004	Ben	10 September	B	12	DOCKS						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Richardson ELNA 6:13 AM 24, 2004 February /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Heatth of North Arunde 1 Burnie Anne ARunde MARINER If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 226-36-4302 81 Dec. 22, 1922 WAShington, O.C Director Usuel Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. Counts in than "natural", or Iteme 23e or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Va. ARLINGTON ARLINGTON 10e. Street and Number 10g. Citizen of What Country? 1121 USA STYEET QUINN 22204 Funeral 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinat once. 1 Yes 2 No If Yes, Give Year or Oates: 1 Never Married 2 Married 1 ☐ Yes 2 No ģ Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Gee Julia Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SEVERN 7728 Tele graph Rd Lester J. Richardson Tr. - Sch Md. 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 3-1-04 Quantico National Triangel 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chinn Funeral Service 2005 de Shirling ron Service Cobect Road ARL. 19122206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** arrheu disease or condition resulting in death) 14 Pax /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 🕱 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No 1 ☐ Yes 1 TYes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certification: To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral D Teartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month. Day Year) J 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 141. Ja ichru 32. Registrar's Signature State Registrar FEB24 2004

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 17, 2004 **Physician** CLARENCE NAPOLEON RICHARDS 13:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES BOWIE BOWIE HEALTH CENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1/7/1915 Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In vrs. last birthday) 6 Sex **Funeral** XX M 2 F OHIO 407-09-6959 89 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at ¶XXYes 2 No Director HEARTFIELD PRINCE GEORGES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 5 20715 USA 7600 LAUREL BOWIE ROAD 'natural', or items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X Xo If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK ģ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NDT use retired) (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) BOARD OF EDUCATION STATIONARY ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LUCIEN RICHARDS JULIA GRAY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum 10006 MARKHAM ST., SILVER SPRING, MD 20901 PATRICE RICHARDS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State BAYVIEW CREMATORY 18 FEB 2004 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FINK FUNERAL HOME, PA 21. Signature of Funeral Service License KELLY GRECORY FINK 426 CRAIN HWY., S, GLEN BURNIE, MD 21061 #M01148 23a. Party. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of): Examiner rorn Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit be executed and Due to (or as a consequence of) P.O. Box 68760. the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year detached for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ģ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 PNo Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 1 Tes 2 PER/Outpatient 3 DOA this 27. Manna of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. м To the Hospital or Attend within 24 hours after death To the Funeral Director: A 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 052139 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 Brander Mill Blvd Svite 220 Gamballs SEJAL MAT 31. Date filed (Month, Day, Year) State Registrar 2 4 2004

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

4	For	State of Ma	aryland / Dep	partifient of r	realth and Me	ental Hygler	1e 2004	0577
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ian	Decedent's Name (First, Middle,						Day Year	3. Time of Death
cal	Ronald	Redman	- de la	4h City Town	r Location of Death		21, 2004 4c. County of Death	10:30 P.
IIC1	4a. Fecility Name (If not institution, Union Memorial H				Baltimore		N/A	
			e (In yrs. last birthda	y) If Under 1 Year		B. Date of Birth (Month, Day, Yes	9. Birth	place (State or Forei
	217-52-5208 Usual Residence of Decedent	XIXM 2 F	56 Yrs.	Months Days	Hours Min.	uly 4, 19	947 Mary	yland
	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limit
ō	Maryland	N/A	Bal	timore				1. Yes 2□N
To Be Completed by Funeral Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	ntry?
a D	3638 Hickory Ave	nue			21211			USA
Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13	 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White,	
	Never Married 2 Marrie	If Yes, Give		1 ☐ Yes XX No			Specify:	white
d by	3 Widowed 4 Divorced	Year or Dates:	162 Dos	cedent's Usual Occu	nation	16h	Kind of Business/In	
Completed	15. Decedent (Specify only highest	t grade completed)	(Gin	ve kind of work done . DO NOT use retire	during most of working d)	g 100.	King of Dusinessin	eduşti y
g E	Elementary/Secondary (0-12)	College (1-4or 5)+)	actory wor			Hedwin/Ma	anufactur:
		ast)			18. Mother's Name	(First, Middle, Maid		
o Be		ledman			Hi1	da Bowen		
-	19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Ma	iling Address (Street	and Number or Rural	Route Number, Cit	y or Town, State, Zij	o Code)
	Beverly Boyer	Friend	130	3 Union A	venue	Baltimore	e, Marylan	nd 21211
	20a. Method of Disposition 1 Daurial 2 Cremation 4 Donation 5 Other (Sp. 21. Signature of Funeral Service L.	pecify)	cemetery, ci	22 Name and Addr	Park 2/2	.5/04 Sy	kesville,	, Marylan
V 3	hand	A Cassent	Tie I	Burgee-He 3631 Fall	nss-Seitz	Funeral H	Home, Inc. ce, Maryla	
Examiner	S pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):					
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by Physic	Cl ! . A1 . 1 . 1 ! .			underlying cause g	ven in Part I.		2 Day 2 Day	the cause of death?
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State Registrar Tasha

CIVEN DEV S M. J. 31. Date filed (Month, Day, Year) FEB 2 4 2004

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/Medic		Tammy	S	argent-Ro	se					Februa	ry 2	1, 200	04	14:25
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Funeral		5. Social Security N			7. Age (In yrs	. last birthday)	If Under 1 Yea	r If Under:	24 Hrs.	8. Date of Bir (Month, Da	th .	9.	Birthpla	ice (State or Fo
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me 23a or 28a-f show crimist be notified at	Funeral Director	6200 Med	dora Roa		de la Electica	10 110		.090				USA		
item item	un.	11. Marital Status	ried 21 <mark>X</mark> 1 Marnie	12. Was Deced	ces?	J.S. 13.	Was Decedent of If Yes, specify Cu	ban, Mexican	n, Puerto	Rican, etc.))-	14. Race - / Black, V		
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if its		1X Burial 2	Cremation	3 □Removal from S	late	_	sition (Name of natory or other pl	1				ocation - City		
rtmer		` 4 □ Donation			La		Mem. Pa			24, 20	04	Syke	svil	le, MD
Department of Health Important; If item 27 any injury or other tronce.		21. Signature of Fu		tackma	m	Ga 72	Name and Addi Ty L. Ka 250 Wash:	aufman	Fune	eral Ho	me a	t Meado	owri 21	.dge MP,
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Medical		resulting in death)		a										
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		1	For State Registrar	State of Maryland /	Department of Health and Note of Certificate of Death	Mental Hygiene	
	Physicia	an	1. Decedent's Name (First, Middle, Last)	UNOWN		2. Date of Death Month Day	Year 3. Time of Death 3. LSA M
}	/Medic Examin Funeral	er	4a. Facility Name (If not institution, give str	7. Age (In yrs. last bi	Months Days Hours Min.	8. Date of Birth (Month, Dev. Year)	9. Birthplace (State or Foreign
dia.	Director	d	Usual Residence of Decedent 10a. Slate 10b. County	10c. City, Tov	Yrs. wn or Location	Aug. 16, 190	10d. Inside City Limits
	with the Mar a or 28e-f sl	Funeral Director	Upry Anu BAITING 100. Street and Number 4 Duke of W.	inpson CA	101. Zip Code 3/307		1 □ Yes 2 5 16
336	72 hours after death with the Maryland natural; or items 23a or 28e-f show neal Examiner must be motified a		1 00100	Was Decedent Ever in U.S. Armed Forces? 1Yes 2No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	i. Race - American Indian, Black, White, etc. Specify: Place
21215-0036	within 72 hou iene. than "natura the Medical E	Completed by	15. Decedeni's Educa (Specify only highest grade) Elementary/Secondary (0-12)		a. Decedent's Usual Occupation (Give kind of work done during most of world life. DO NOT use retired) He U JEWH	rking	d of Business/Industry Light 6-
pu	should be filed nd Mental Hygid marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) ROBERT Taylor	Origan) 10	18. Mother's Nar CENTO. b. Mailing Address (Street and Number or Ru		
Baltimore, Mar	jes 1 and 2 of Health a if item 27 is or other tree	,	19a. Informant's Name/Relationship (Type 20a. Method of Disposition 15 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	movel from State 20b. Place comet	of Disposition (Name of entry, crematory or other place)	19alg JUY 20c. Loca	Ation - City or Town, State
Baltir	permit. Pag Dependent Important: any injury o		21. Signature of Funeral Service Licensee	esto	Name and Address of Facility Reliable Balthou 14, 14	A TAIM - 14	Approximate
760,	Associated and Associated Associa	Ical Examiner	Sequentially list conditions, if any, leading to imprediate cause (Final mease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Last	Due to (or as a consequence	ccancer from	pancrear	Interval Between Onset and Death
P.O. Box 68	ath certifica ttending ph or use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mophs? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, oulcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time ol death 9 Unknown	th 3 Ectopic pregnancy 5 Other (specify)	23	3d. Date of delivery Month Day Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions cont	ributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?
al Reco	The law ate has b	Completed			00 Plan of Do	24a. Was an autopsy performed 1 Yes 2 No	A24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No
Division of Vital Records,	ding Phys	ation; To Be	27. M. n. er of Death 1 Shatural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 EP/0 28a. Date of Injury (Month, Day Year) 28b	Others	Home 5 Residence 6 28d. Describe how injury	
Divis	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At home, building, elc. (Specify)		City or Town, State)	Number or Rural Route Number,
	the Hosp thin 24 hou the Fune impletely fi	Medical	29a. Certifier (Check only one) 29b. Signature and title ol certifier	er: On the bast of my knowled ar: On the basis of examination and manner stated.	Ige, death occurred at the time, date and plac and/or investigation, in my opinion, death occ	urred at the time, date and p	signed (Month, Dey, Year)
	F 3 F 8		1. Many the	mpleted cause ol death (Item 23a	A) (Type, Print)	16 2-	20-04
	St Regist	ate	31. Date filed (Month, Day Feb 2 4	32. Registure s Signature	Crossroads DC#	240 Own	smills, mD 21117

				State of Maryland / Department of Health Certificate of Deat	h and Me	ntal Hygi	eneo o o	
				1 - For State Registrar Certificate of Deat	th	Reg	1. No. 2004	05782
		Physicia	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Yeer	3. Time of Death
		/Medic	al	Erasmo Rodriguez 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location		ebruary	21, 2004 4c. County of Death	1:00 pM
		Examin	er	Joseph Richey Hospice Baltimore			Baltimore	
ZI		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Yea		Date of Birth (Month, Day,		
		Director		579-56-2743 NAM 2 F 87 Yrs. Usuel Residence of Decedent	l l'é	bruary	24,1916 Mex	(ico
40		yland how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
_		8a-f s	Director	Virginia n/a Falls Church		10	000000000000000000000000000000000000000	NXYes 2 □ No
2		72 hours after death with the Maryland *netural; or Itema 23a or 28a-f show idical Examinar must be nutified at		10e. Street and Number 10f. Zip Code 7312 Lee Highway, Apt. 104 22046		Un	g. Citizen of What Cou ited State America	
0		death	Funerai	7312 Lee Highway, Apt. 104 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexic	Origin? (Specif		14. Race - Ameri Black, White,	
•	36	s after , or Ite	by Fu	1 ☐ Never Married XXX Married 1 ☐ Yes 2XXX No	city:		Specify:	
0	9	thours stural	ed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	Mexic	10	Wh Sb. Kind of Business/Ir	ite
20/04	21215-0036	3 within 72 ho piene. r than *natur ine Madical	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) (Give kind of work done during mile. DO NOT use retired)	most of working			
13	121	lled wi tygien her th nt, the		12th Waiter 17. Father's Name (First, Middle, Last) Waiter	other's Name /F	First Middle Ma	Food Serv	ice
17	and	d be filed ental Hyg ked othe ic event,	To Be		caria R		,	
	Maryland	s 1 and 2 should be filed within 72 hours after of Health and Mental Hyglene. Item 27 Ie marked other than "natural", or lite other traumatic event, the Madical Examina	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num			City or Town, State, Zij	Code)
9	\geq	permit. Pages 1 and 2 Department of Health a Important: if Item 27 le eny injury or other tra		Erasmo Rodriguez (Nephew) 3554 Hummock Place 20a Method of Disposition (Name of	e; Woo	-	, Virginia	
PIRED	Baltimore,	ages 1 nt of H : If Ite		1 ☐ Burial 21XCremation 3 ☐ Removal from State Fiver IV—Wheatley	Feb 2			
0	Itin	artmer ortant injury		1 □ Donation 5 □ Other (Specify) Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Fac	2004 acilityLoudo	n Park	lexandria, Funeral Ho	me
7	B	Per Open		Your () Crincary.	Balti	more, M	laryland 21	
9				2.a. Rant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.			st,	Approximate Interval Between Onset and Death
		Physician /Medical	0	resulting in death)	Cance	r		5 years
	1	Examiner		Due to (or as a consequence of):				
	**************************************	P ==	iner	Sequentially list condition figure and adding to immediate cause. Enter Underlying				
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3	68	leath certificate attending physic lor use as the	Medi	IF FEMALE.				
5	Вох	ath ce	Physician/Medi	23b. Was decedent pregnant 1 Live birth 2 Fetel death 3 Ectopic pregnancy			23d. Date of deliv Month	ery Day Year
od R	P.0.	that the death ed by the atte detached for	yslc	1 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown 9 □ Unknown				
90		Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I.		cco use contribute to t	
\subset	ord	w require been si should b		rypertension Diaberes Wellins / ype 2		-	2 No 3 Pro	bably 4 Donknown
	of Vital Records,	ne faw has b ge 2 sl	Completed	history of lung course, weteral obstruction	Tan	24a. Was an autopsy performy	prior to co	opsy findings available impletion of cause of
2 x	tal	ician: Th certificate rector, pag	ø	25. Was case referred to medical 26. Pla	lace of Death (No 1 ☐ Yes	21546
PASM	Ĭ	ding Physician: The larn. n. After this certificate has funeral director, page 2	To B	examiner? Hospital:	Nursing Home		2	m hispice
2		ling P. After t	ion:	27. Manner of De ith 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Work? M 1 Ves 2		d. Describe how	injury occurred	
(T)	Division	Attending ir death. ector: After by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		. Location (Stre	net and Number or Run	al Route Number,
×	Di	tal or	Cert	4 ☐ Homicide determined building, etc. (Specify)	4	City or Town,	5(4(4)	
`		To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	edical	29a. Certifier (Check only one) Sertifying Physicien: To the best of my knowledge, death occurred at the time, date (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, dand manner stated.	e and place, and death occurred	d due to the cau at the time, dat	ise(s) and manner as s e and place, and due t	stated. o the cause(s)
_		Fo the within ?	Med	29b. Signature and title of certifier 29c. License number 29c. License number	per	290	d. Date signed (Month,	Day, Year)
)		Mont Mardonald 12 1930	105		2/21/04	
		o'		30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)	0 12	with in	0 2016	
		Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	/	eur j	W 200	
		Registi		FEB 2 4 2004				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 05783 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 22,2004 7:00 A M ROSENFELD AZRIEL 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) TOWSON BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB.19,1931 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 □ F Months Davs Hours NY 084-30-9533 73 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 Ves 2 No N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 U.S.A. 6701 PARK HEIGHTS AVENUE #3-G 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🗓 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) UNIVERSITY OF MARYLAND **PROFESSOR** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **CHADABE** ROSENFELD IDA ABRAHAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6701 PARK HEIGHTS AVENUE #3-G BALTIMORE, MD 21215 EVE ROSENFELD / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) SEDEK 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State SHOMREI HADATH VE TZEMECH 2/23/04 ROSEDALE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 112100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) conces 1000 ieas Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ther (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No

/Medical Examiner The law requires that the death certificate be executed physician as the burial-1 P.O. Box 68760, the

Division of Vital Records,

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-1 show

Funeral Director

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Completed

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Examine

Physician/Medical

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Completed

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Certification:

Medical

cate has been signated page 2 should b

After t

death.

or Attendate after death

To the Hospital within 24 hours a To the Funeral E

item 27 is marked other than "natural", or Items 23s or 28s-1 shov other traumatic event, the Mudical Examinan must be mailfied at

and Mental h

item 27 is

important: If item.
any injury or other

Physician

Pages 1 and 2 should be

Maryland 21215-0036

Baltimore,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 TUnknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

27. Manner of Death 2 Accident 3 🗌 Suicide

4 Homicide

Itelen

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltmare

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M.

29d. Date signed (Month, Day, Year)

D0051926

04

State Registrar

0

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ander

6565 32. Registrar's Signature N. Charles

State of Maryland / Department of Health and Mental Hygiene 001 05784 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 22,2004 **Physician** ROSINA 9:35 A M OLGA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORE 7055 TOBY DRIVE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) BELARUS 8. Date of Birth MAY 3, 1917 5. Social Security Number **Funeral** Days Months Hours Min 1□M 20 F 220-35-2672 86 Vre Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 21209 BELARUS 7055 TOBY DRIVE or Itama 23a Funerai 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify þ 3

Widowed 4 □ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) NURSE MEDICAL other i 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) rmit. Pages 1 and 2 should be file partment of Health and Mental Hy portant: If itsm 27 is marked oth y injury or other traumatic svent Be MAY7UF BENSON NACHAMA (UNKNOWN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15-C FRIENDSWOOD COURT - BALTIMORE, MD 21209 SOFIA KOGAN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If sny injury or once. BALTIMORE HEBREW CEM. 2/23/2004 REISTERSTOWN, MD *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 THIVANI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MUMENIA 75 CARDIOPULMONARY ARREST /Medical Due to (or as a consequence of): Examiner WOART DISCAY CORONAM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Started Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide fo the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 125039 completed cause of death (Item 23a) (Type, Print) ss of person 2835 SMITH AVE BALTIMORE, MID MD. 31. Date filed (Month, Day, Year 32. Registrar Signature State 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 200 4

		•	1- State Registrar/MEND ITEM #18 PER FH G828 2/24/04 Se	ertificate of	Death	Re-	ig. No.	
	- · · ·		Decedent's Name (First, Middle, Last)			2. Date of Deat Month	h Day Yea	3. Time of Death
	Physicia /Medic		KOSE KAVINSKY	/		TEBRUK	ry 20 200	1 Linn
	Examin		4a. Facility Name (If not institution, give street and number)		or Location of Death		4c. County of De	
			NORTHWEST HOSPITAL COSTER		mallsten			neat
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.	Months Days	Hours Min.	8. Date of Birth (Month, Day, JUNE 8,	Year) 9. E	Sirthplace (State or Foreign Country)
12	Director		210-10-9327 A 00	•		JUNE 8,	1923	MD
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	r Location				10d. Inside City Limits
	faryli sho	ō	MD BALTIMORE BA	LTIMORE				1 ☐ Yes 2 ☐ No
	28a-1	Director	10e. Street and Number	10f. Zip Code		10	0g. Citizen of What	
	death with the Maryland ms 23a or 28a-f show rmust be nutified at		130 SLADE AVENUE #225		21208			U.S.A.
	ns 23	Funerai		13. Was Decedent of H If Yes, specify Cub		pecify Yes or No-		merican Indian,
		F	1 ▼Never Married 2 Married 1 Yes 2 No			o Rican, etc.)	Black, W	
8	hours after death with the Marylar tural; or items 23s or 28s-f show al Examinar must be nutilled at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No	Specify:		Specify:	WHITE
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21	within 72 ene. then 'nai	pie	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retire	d)	, , , ,		
2	filed within I Hygiene.	Con	12 SECR	ETARY	1			ING AGENCY
2	be filed within 72 ho ital Hygiene id other then "natur event, the Medical	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, M		
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Maryland	2 sho and is ma			ailing Address (Street				
	s 1 and 2 should I Health and Mer Item 27 is marke other traumatic			6 EVESHAM	AVENUE -	-		
ore o	00-		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	isposition (Name of crematory or other pla			20c. Location - City	
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Bail	permit. Pag Department important: I eny injury o		21. Signature of Funeral Service-License	22. Name and Addre	9.		SON & BROS	
	0 0 7 • 0		sien III unen					, MD 21208
P			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dyl	ng, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	my OC	MAD 4L	INT OH	CTION	
B	/Medical Examiner		Due to (or as a consequence of):	/				
		<u>_</u>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):					
	ted sit	Examiner	Cause, Enter Underlying Cause (Disease or injury					Ì
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68760	icate be executed physician and s the burial-transit		d					
189	entificate ding phy se as the	Medicai						
ŏ	nding use g		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, oulcome of pregnancy	200			23d. Date of	delivery
\mathbf{m}	death e atte d for	icia	in the past 12 months? 1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \)	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	;y 		Month	Day Year
Ö	that the death cer ed by the attendin detached for use	Physician	9 ☐ Unknown					
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ğ	w require been sig	ed	Alite PANCREALITIS, CONCA	stry Ax	tray Dis	1 Ye	es 2□No 3☐	Probably 4 □Unknown
000	aw re	piet	CHARACTE BASTRUCTIVE Line	DISEASE	<u>, </u>	24a. Was a		autopsy findings available o completion of cause of
œ e	sicien: The law requires that the death certificate be executed certificate has been signed by the attending physician and irrector, page 2 should be detached for use as the burial-transit	Completed	RENAL FAILURE	•		perform	ned? death	
ita	ien: rtifica	Be	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only on		
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0 0	ng Pl fter ti nera	:uo	27. Manner of Death 28a. Dale of Injury 28b. Tim 1 ☑ Matural 5 ☐ Pending (Month, Day Year) Inju		ry at ork?	28d. Describe ho	ow injury occurred	
sio	eath. or: A	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home farm		Yes 2 □No			
Division of Vital Records, P.O.	or Atl fter d direct in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office		28t. Location (St City or Town	reet and Number or n, State)	Rural Route Number,
	urs a urs a sral C			tth-			()	
	To the Hospital or Attending Physicien: The i within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier Certifying Physician: To the best of my knowledge, do (Check only one) Medical Examiner On the best of my knowledge, do (Check only one) Medical Examiner On the best of my knowledge, do (Check only one) Medical Examiner On the best of my knowledge, do (Check only one) Medical Examiner On the best of my knowledge, do (Check only one) Medical Examiner On the best of my knowledge, do (Check only one) Medical Examiner One one) Medical Examiner One one) Medical Examiner One one one of the best of my knowledge, do (Check only one) Medical Examiner One one one of the best of my knowledge, do (Check only one) Medical Examiner One one one one of the best of my knowledge, do (Check only one) Medical Examiner One one one one one one one one one one o					
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			1 (Ma (MA	1	19562	7	05/6. A.L.	26 2801
	10		30. Name and address of person who completed cause of death (Item 23a) (Ty	/pe, Print)	N.		Har	Cala
	•		CRIANDE B. COMANAN MID		PHUDO	1152011	and in	28 2804 14 Centera 2-1132
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature					
	Regist	rar	FFR 2 A 200A No Ad	13 100				

State of Maryland / Department of Health and Mental Hygiene 2004 For Stete Registrar 05786 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Feb. 20, Robert C. 2004 1:15 p.[™] Redman, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Co. Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Aug. 12, 1 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 86 213-10-2642 Director 1917 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ul Hygiene. other than "natural", or items 23a or 28e-f show vent, the Madical Exeminat transit te notified at 1 Yes 2 □ No Directo Baltimore Maryland n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2738 Kildaire Drive United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Realtor Real Estate 10 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other treumatic event QMC8. Arthur M. Redman Sadie ٧. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Roberta E. Valderas /Daughter 9059 Furrow Avenue Ellicott City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2/23/2004 Gardens of Faith Baltimore, MD 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Michael E. Canapp 5305 Harford Road Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ageal **Physician** CANCER ph monther /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intracted events. Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Be Completed by Physician/Medical use as attending p IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) signed by the a □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has be irector, page 2 s. 1 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No Certification: To 6 Other (Specify) Director: After the in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
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completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) February 20, 2004 un 30. Name and address of person who completed cause of death (New 29a) (Type, Pript). Balto. Md 21204 32. Registrar's Signature State Registrar

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Physician /Medical	1. Decedent's !				uncate c	of Death			g. No.	4 0578
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Maryland show	Usual Residen 10a. State MD	10b. County Baltin	1	City, Town or Lo		ssex				10d. Inside City Limits 1 ☐ Yes 3 ☐ No
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Pa ment ury		f Disposition 2 ☐ Cremation 3 ☐ I tion 5 ☐ Other (Specify)	demoval from State	Place of Dispo cemetery, crer AkLawn	Cemet	ery	2/27	/04	20c. Location - City of Baltimo:	re MD
permit. Departr Imports any inji	L ► K	of Funeral Service Licens	dications that caused the done cause on each line.	11	30	0 Mac	e Ave	. Balt	imore M	omeofEssex
requires that the death certificate be executed seen signed by the attending physicien and hould be detached for use as the burial-transit and hould be detached for use and hould be detached	timediate Cadisease or coresulting in de Secuentiality if any, leading cause. Enter Cause (Diseathat initiated e resulting in de	use (Final notition ath) seconditions, to immediate Underlying se or injury wents	Due to (or as a cons CNG Peff Due to (or as a cons c. Intracer Due to (or as a cons d.	equence of): +5510 n equence of):						onset and Death
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uires that the death signed by the atterid be detached for d by Physicial	Pairii. Other	significant conditions co	ontributing to death but not i	resulting in the u	nderlying cause	e given in Par	t I.	23e. Did tot	*	to the cause of death? Probably 4 Unknow
The law ate has b page 2 s									ry prior t med? death 2 No 1 □ Y	autopsy findings available o completion of cause of ? es 2 \(\text{No} \)
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thin 24 hour thin 24 hour the Fune mpletely fill	29a. Certifier (Check o one)	1 Certifying Ph 2 Medical Exam	ysician: To the best of my I liner: On the basis of exam and manner stated.	knowledge, deat lination and/or in	n occurred at the investigation, in the	ne time, date my opinion, d	and place, an eath occurred	at the time, d	ause(s) and manner ate and place, and d	as stated. lue to the cause(s)
To the within To the comp	29b. Signatur	e and title of certifier				cense numbe	٢	İ	9d. Date signed (Mo	
4	30. Name and	d a dress of person who	completed cause of death (I	Item 23a) (Type.	Print)		· CO	M D D	1727	24,2004

State of Maryland / Department of Health and Mental Hygienes 05788 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4:18P February 19, 2004 Schwartz Dorothy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Cromwell Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 21, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 ☐ M 2 ☐ F 214-22-5553 89 1914 Ohio Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinst must be invitibed at 1 Yes 2 No Director Baltimore Edgemere filed within 72 hours after death with the I Hygiene. 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21219 U.S.A. 2416 Eugene Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Brainard Essie (Unknown) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Schwartz / Son 2416 Eugene Ave., Edgemere, Md. 21219 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Balto-Wash.Crematory | 2- 22 -04 Laurel, Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licen Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md. 21222 23. P. 1. Ent. the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mill **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the atten detached for u in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? ÀD No 1∐ Yes 1 Tyes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Mapner of Death 28c. Injury at Work? Certification: il or Attending P rafter death. I Director: After to d in by the funera 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours af To the Funeral D completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number multin faymer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 June MO 12 56 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

ORIGINAL

AMEND ITEM #7&19a&b PFE take 6829a 3/17/07 Department of Health and Mental Hygiene 1- State AMEND ITEM #1 PER PHY G829 3/11/04 Bertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2215 Southern February 16. 2004 Joann Joan Southern /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year) 6/29/1925 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Days OHIO" 1 ☐ M 2100XF 73 78 Yrs. 289-20-5976 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c City Town or Location 10a State 10b. County ne 23a or 28a-f ahow 1 Yes XX No Directo Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 USA 1335 Douglas Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "netural", or Itam 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Completed by 3XXWidowed 4 □ Divorced 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse Health Care 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 Is marked off jury or other traumatic aven Be Howard C. Kittelberger Renata Eyler 19a. Informant's Name/Relationship (Type, Print)
LAURA SOUTHERN-JONES /DAUGHTER
Renira Southern 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44h ST N.W. WASHINGTON, DC 20011 1335 Douglas Avenue, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Aburial 2 □ Cremation 3 ▼ Removal from State
1 □ Donation 5 □ Other (Specify) permit. Page Department of Important: If any Injury or once. 2/23/2004 Akron, OH Glendale Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility FINK FUNERAL HOME, PA MELLY ORLOOM 426 CRAIN HWY., S, CLEN BURNIE, MD 21061 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lly one cause on each line. Approximate fnterval Between Onset and Death Part1 Enter the disease, or oshock, or heart fail a List Immediate chuse (Final disease or condition resulting in death) Myeloma Physician two 448 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 🗌 Yes 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 / npatient 2 ER/Outpatient 3 DOA P this After thi 27. Manner of Death 28c. injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 tro Fenn 31. Date filed (Month, Day, Year) Registrar's Signature State 2 4 2004 FEB Registrar

			1 ~ For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of Hertificate of L	ealth and M Death	ental Hygi	iene g. No. 200	4 05790
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	Examin Funeral Director	er	6410 ALTAN 5. Social Security Number 6.5	10 N	**		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 8,	BALTYear) 9. Bi	n o R E Thplace (State or Foreign ountry) cryland
	Maryland	tor	10a. State 10b. County Maryland Balti		y, Town or Lo	cation tonsville			,	10d. Inside City Limits 1 □ Yes 文页No
	th with the 23e or 28e	Funeral Director	10e. Street and Number 6410 Altamont Ave	enue		10f. Zip Code	21228	10	og. Citizen of What C USA	
036	within 72 hours after death with the Maryland ene. than "naturel", or tlema 23e or 28e-f ahow the Madreal Exemiter must be mailfied at	þ	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2€XNo	spanic Origin? (Spe n, Mexican, Puerto I Specity:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
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Baltir	permit. Pag Department Important: any injury c		21. Signatura Theral Service Lid	Carpertu	B 3	. Name and Address urgee-Hens 631 Falls	s of Facility SS-Seitz Road Ba	Funeral Itimore.	Home, Inc	
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Divis	ital or Atteners after deathrai Director: led in by the	Certification:	3 Suicide 6 Could not be determined		me, farm, str	eet, factory, office	2	8f. Location (Stre City or Town,	eet and Number or R. State)	ural Route Number,
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Example one) 29b. Signature and title of certifier	hysician: To the best of my knowminer: On the basis of examinat and manner stated.	ion and/or inv	restigation, in my opi	inion, death occurre	d at the time, da	te and place, and due	to the cause(s)
•	7)		30. Name and address of person who	Auran II U completed cause of death (Item	23a) (Type,	D /	117/	F	LARVARY	18,2004
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			1 - For State Registrar	State of Mar	yland / Depa	artment of	Health and Death	Mental Hy	giene 200L	+ 05791
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	Director		213-34-1202 Usual Residence of Decedent	X M 2□ F 6	7 Yrs.	Months Da	ys Hours M	in. B. Date of Birt (Month, Day Nov. 2)	6,1936 Ma	Birthplace (State or Foreign Country) Vryland
	ith the Marylar or 28a-f show	Olrector	Maryland Baltimo	re	0c. City, Town or Lo	Balta 10f. Zip Cod			10g. Citizen of What	10d. Inside City Limits 1 Yes 2 No Country?
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d 21215-0036	ould be filed within 72 t I Mental Hygiene. varked other then "nati vatic event, 'ne Wedica	e Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12) 8th Grade 17. Father's Name (First, Middle, Last)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Ockind of work do. DO NOT use rel	ne during most of v lired) INGLET	vorking lame (First, Middle,	16b. Kind of Busines Manufactu Maiden Sumame)	
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Baltimore, M	permit. Pages 1 and 2 Department of Health s Important: If item 27 li any injury or other tra <u>once.</u>		Mr. Allan Setzer 20a. Method of Disposition 1 X Burial 2 Cremation 3 Company 4 Donation 5 Other (Specify		20b. Place of Dispo cemetery, crer	sition (Name of natory or other p	place)	Date	MD 2123	or Town, State
Baltir	permit. Pages 1 Department of F Important: If ite any injury or ot		21. Signature of Funeral Service tricen	999	22	9705 Be	dress of Facility Sc Lair Rd.,	chimunek 1 , Baltimo	Baltimore, Tuneral Ho re, MD 21	marykana mes 236
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Division	i Sir G	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, stre Specify)	eet, factory, offic	ee ·	28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,
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	¥		29b. Signature and title of certifier	full to	200		2 4 3 5 6		9d. Date signed (Mor	
	4	10	30. Name and address of person who fund the Control of ATENA 31. Date filed (Month, Day, Year)	ompleted cause of death C E	Signature	IN G	Hosp	Center	feb 23,	ma M/ 2123;
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Bernard Sexzed 2.22-04

				For State Registrar	State of Maryland / Department	artment of Health and rtificate of Death	Mental Hygier	ZHIII 116 100
•		Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) LJ/LJON 4a. Fecility Name (If not institution, give stre	Smith, Sr. pet and nymber) Laspice	4b. City, Town, or Location of Deat	FEB 2	Day Year 1 2004 3. Time of Death 3. 15 AM 4c. County of Deeth
	2.	Funeral Director	d	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
		death with the Maryland ms 23a or 28a-f show rmust be notified at	Director	10a. State 10b. County Mary land 10b. County 10e. Street and Number	10c. City, Town or Lo	Ocation 31 h M S P C 10f. Zip Code	10g. (10d. Inside City Limits 15 Yes 2 □ No Citizen of What Country?
	36	72 hours after death wit "natural", or items 23a o edical Examinar must be	by Funeral	36JY MANCHESTER 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2云No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Tyes 25 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
	d 21215-0036	ould be filed within 72 hours after Mental Hygiene. arked other than "natural", or ite atic event, the Medical Examina	Completed	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12) 6 4 9 3 de 17. Father's Name (First, Middle, Last)	ompleted) (Give	dent's Usual Occupation kind of work done during most of wo. DO NOT use retired) GGCW 18. Mother's Nar	rking 16b.	Kind of Business/Industry (Luca Rigging Co.
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3 15 8	Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 shot any injury or other traumatic event, the Medical Examinar must be notified at 2008.		20a. Method of Disposition 20a. Method of Disposition 3 Gen 4 Donation 5 Other (Specify) 21. Signature of Funeral Service icensee	20b. Place of Disportance of Disport	Charten 2. Name and Address of Facility 2. Va PE I TEXT	28/04 BA	Location - City or Town, State Minuse Marylons - Harris Turens Land
		Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequential, list contriers if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	tions that caused the death. Do not encause on each line.	er the mode of dying, such as cardial Colum (amcer	c or respiratory arrest,	Approximate Interval Between Onset and Death 6 man His
्रिक्री	. Box 68760,	ne death certificate be executed the attending physician and shed for use as the burial-transit	by Physician/Medical Exa	IF FEMALE: 23c Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Smith	Records, P.O	n requires that the been signed by should be detacted.	Completed by Phys	9 Unknown Part II. Other significant conditions contri Cardiae arrythm hypothyroidism	buting to death but not resulting in the unit Nos Congo		1 ☐ Yes 24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Vilson	of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has comple ely filled in by the funeral director, page 2.	To Be	1 103 2	spital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing F	performed? 1 Ves Ath (Check only one) tome 5 Residence 28d. Describe how in	No 1 □ Yes 2€No 6 Maher (Specify) MSpire
	Division	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A comple ely filled in by the fu	ai Certification;	4 Homicide 29a. Certifier 1 Sertifying Physic	28e. Place of Injury - At home, farm, st building, etc. (Specify) ian: To the best of my knowledge, deat	h occurred at the time, date and place	City or Town, Sta	(s) and manner as stated
•		To the Ha within 24 P To the Fu comple ely	Medical	29b. Signature and title of certifier	fr. On the basis of examination and/or in and manner stated.	29c. License number D47105	irred at the time, date a	Date signed (Month, Day, Year)
		Sta Regista		31. Date filed (Month, Day, Year) FEB 2 4 200	32. Registrar's Signature	bodi	E, But	mo zizig

04-01356 Robert Snyder RJD

■ Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ysician		Decedent's Name (First, Middle, I								2. Date of De Month Febual		20	Y22/2	3. Time of Death 1813P. M
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neral ector	5	. Social Security Number 216-86-3898	Sex 1 1 1	ge (In yrs. 29	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Da Jan 2	th 19, Year) 16, 1	975	9. Birthp Coun Ma	lace (State or Foreign try) ryland
-	_	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	Od. Inside City Limits
tor.		Maryland Baltin	nore	I	Baltimo	ore								1√ Yes 2 No
event, the Medical Examinat must be multified at Be Completed by Funeral Director	1	0e. Street and Number				10f. Zip					10g. Citiz			•
eral		911 Imperial Cou	12. Was Decedent	Ever in II	S 13		1227	snanic Or	igin? (Sp	ecify Yes or No	- 1		S -	A • an Indian,
Completed by Funeral Director	'	1 X Never Married 2 Married	Armed Forces' 1 ☐ Yes 2 🔯	?		f Yes, spec	orfy Cuba	n, Mexicai	n, Puerto	Rican, etc.)		Black	, White,	etc.
d by		3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1□ Yes		Specify:				Specify:		White
olete	1	15. Decedent's (Specify only highest	grade completed)		16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	rk done a	lurina mos	st of work	ing	16b. Kir	id of Bus	iness/Ind	dustry
E O		Elementary/Secondary (0-12)	College (1-4or	5+)	Labo	rer_					F	ırni	ture	Mover
Be	1	7. Father's Name (First, Middle, La John Guy Snyder								e (First, Middle) e Carol)	
2	L.	19a. Informant's Name/Relationship			19b Maili	an Addross	(Street a			al Route Numb			tate Zin	Code
ToT		Denise Booth, m				-				Winche	-			2602
	12	20a. Method of Disposition	DD	1 ^	Place of Dispo emetery, crea	sition (Nam	ne of ther place	e)		Date	20c. Loc	cation - C	ity or To	wn, State
		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	Ced	lar Hil					5-04		ok1yı	n, :	MD
any injury or other tra		21. Signature of Funeral Service Lie	censee		2:	Ambro 1328	d Addres Se E Sulp	s of Facili uner hur	al H Spri	ome, In	c. Arbui	tus,	MD.	21227
	1		omplications that cause by one cause on each	d the deat ine.	h. Do not en									Approximate Interval Between
n		Immediate Cause (Final disease or condition resulting in death)	a. Narcotio	and E	Ethanol	Intoxi	cation	n						Onset and Death
il r		resulting an dealth)	Due to (or as	a conseq	uence of):									
je l		Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseq	uence of):									
Physician/Medical Examiner		cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	c Due to (or as											
caiE		,	Due 10 (01 a:	a conseq	derice or).									
ledic			d									-		
Physician/Med		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Feta	I death 3	Ectopic pr					2	3d. Date Mont		ory Day Year
ysici		1 Yes 2 No	4☐ Pregnant a 9☐ Unknown	at time of d	eath 5[Other (sp	ecify)							
		Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying c	ause give	en in Part	1.	23e. Did t	obacco u	se contrit	oute to th	e cause of death?
ed by		Cocaine Use								1 🗆	Yes 2	₹ No 3	B ☐ Prob	ably 4 Unknown
Completed			·							24a. Was		pr	or to cor	psy findings available appletion of cause of
tion: To Be Comp										1 Porto	ormed? 2 ☐ No	11	ath? Yes	2□ No
o Be		25. Was case referred to medical examiner? N∑Yes 2 □ No	Hospital:	ant 2	ER/Outpatie	a a D DC	Othe	200		h <i>(Check only c</i> ome 5 ☐ Resi		™ Oshar	/Ch	(SCENE)
n: To	160	27. Manner of Death	28a. Date of Inj four(Month, D		28b. Time of		28c. Injury Work		ursing no	28d. Describe				/) (500110)
atio		1 Natural 5 Pending investiga	tion 2/20/04	ay rear/	6:00	pM	1 🗆 ,		No No	unknown				
Medical Certifical		3 ☐ Suicide 6 ☑Could no 4 ☐ Homicide determin	ed 289. Place of Ir building, e		ome, farm, st fy)	reet, factor	y, office			28f. Location (911 <i>City of To</i> 911 Imper				ne,MD
edical Certification:	-	29a. Certifier 1 ☐ Certifying	reside Physician: To the bes		owledge, deal	h occurred	at the tim	ne, date a	nd place,					
edic	3		aminer: On the basis and manner s	of examina										
Σ		29b. Signature and title of certifier	1/				c. License). C.M			į	29d. Date Febu	signed lary	(Month, 21,	2004
	-	30. Name and address of person w		chath (lice	1 23al (Tun-	Print)	11 -	- 33	0.1	-4 5 7				lond 01001
		So, maine and address opportion w	G. APPLE	S		- mil)]	TT P	enn :	stre	et, Bal	CTWOI	e, N	ary.	land 21201
State		31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ature	park	11							
egistrar		デーラ 9 A 70円/	1 25 900	-	had de	こくほしね イビ	1							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 2004 6:20AM /Medical 4b. City, Town, or Location of Death Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner HimoRe SALtimoRe 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1**X** M 2□ F 54 212 50 4517 Maryland Director Aug. 31, 1949 Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Merylend nent of Heeith end Mental Hygiene. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frems 23s or 28s-f sho traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 21 No Maryland Baltimore Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 14 Gilland Court 21236 U.S. Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Merital Status 1XI Yes 2 No If Yes, Give Viet Nam Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0020 Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Military 12th Army 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h end Mental F Is marked of Max James Schlauch Moira Hackett 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Kimberlee Schlauch / Daughter 2332 Emory Road Apt. A Reisterstown, MD. 21136 of Heelth 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Depentment o MD. State Veteran Cem. 4/20/04 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) PANCREATITIS /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed attending physician end for use as the burial-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed? †□Yes 2EtNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA this: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of It Director: After the Certification: Division 1, Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter d To the Funeral Direct completely filled in by 4 - Homicide edicai Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) and manner as steted. Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the th

State Registrar

31. Dete filed (Month, Day, Year) FEB 2 4 2004

29b. Signeture and title of certifie

Chen, M.D 32. Registrar's Signeture

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 2 0 0 1

		1	For State Registrar	State of Maryland	Cer	tificate	of Death		Reg	1. No.	
	Physicia	in	. Decedent's Name (First, Middle, Last) MELIN	DA GOLI	SMITH		STEIN		2. Date of Death Month FEBRUARY		
	/Medic Examination	er 4	a. Fecility Name (If not institution, give str SHADY GROVE ADVENT Social Security Number 579-88-5828		- 1	G If Under 1	AITHERS Year If Under Days Hours	BURG	8. Date of Birth Month, Day, 1 JULY 31,	9. Bir	GOMERY Inthiplace (State or Foreign ountry) D.C.
	Director wods	-	Jsuel Residence of Decedent 10a. State 10b. County		, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the h	ā	10e. Street and Number 90 MONROE STREET	(OTIEN)		10f. Zip C	ode 20	850		g. Citizen of What C	U.S.A.
220	filed within 72 hours after death with the Maryland Hygione. Ither than "natural", or items 23s or 28s-f show ant, the Medical Exam or must be notified at	by Funeral		2. Was Decedent Ever in U.: Armed Forces? 1		Was Deceder f Yes, specifi 1 ☐ Yes 20	nt of Hispanic Oi y Cuban, Mexica No Specify		cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0030	within 72 hou ane. than "natura ha Medical E	Completed	15. Decedent's Educa (Specify only highest grade	ation completed) College (1-4or 5+)	lite.	dent's Usual kind of work DO NOT use		st of workir	ng	6b. Kind of Business	s/Industry
anu z	b d d	Be	17. Father's Name (First, Middle, Last) DAVID	Н.	GOLDS		18. Moth	ner's Name	(First, Middle, M	aiden Sumame)	SCHOLD
Maryland	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	7	19a. Informant's Name/Relationship (Type ALAN STEIN - HUSBA	e, Print)	19b. Mailir	ng Address (City or Town, State, MD 20850	Zip Code)
altimore,	Pages 1 and nent of Health int: If item 27 iry or other to		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b. P	lace of Dispo emetery, crei SINAI	osition (Name matory or oth CEME	e of ner place) TERY	2/22/	2004	Oc. Location - City o	ILLS, MD
Bait	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service License	in		8900		NWOT	ROAD -		E, MD 21208
57	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ASP	IRATIC		of dying, such a	s cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death 6 DAYS
68760,	ficate be executed p physician and ts the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq	uence of):						
P.O. Box 6	death certii e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 🌣 Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	l death 3	Ectopic pre				23d. Date of d Month	delivery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con TAY-SACHS DISE		ulting in the t	underlying ca	tuse given in Par	t I.	1 □ Ye	s 2 💢 No 3 🗆	to the cause of death? Probably 4 Unknown
of Vital Records,	The ate h page	Completed	25. Was case referred to medical				26 Pla	ice of Death	24a. Was an autops perform 1 Yes 2	y prior t death 2 X No 1 □ Y	autopsy findings available o completion of cause of ? es 2 17 No
ion of Vit	S S	ation: To Be	evaminer?	ospital: 1 X Inpatient 2 = 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury			Nursing Ho	me 5□Reside	once 6 □Other (S) ow injury occurred	pecify)
Division	Diff.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	fy)				City or Towr	n, State)	Rural Route Number,
	the Hospitel in 24 hours the Funeral pletely filled	ledical	(Check only 2 Medicel Examily one)	sician: To the best of my kniner: On the basis of examination and manner stated.	owledge, dea ation and/or i	nvestigation,	in my opinion, d	eath occur	red at the time, d	ause(s) and manner ate and place, and d 9d. Date signed (Mo	ide (o ille cause(s)
		Σ	29b. Signatur and title of certifier	()	M	6	. License numbe	58681	2		RY 19, 2004
	B			@ SHADY GRO			HOSPIT	AL			
8	St Regis	ate	31. Date filled (Month, Day, Year) FEB 2 4	32. Registrar' Sign	ature	4	Spark	1			

State of Maryland / Department of Health and Mental Hygiene 2004 05796 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 20,2004 **Physician** 9:30 A SULPOVAR IRINA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORE JEWISH CONVALESCENT CENTER If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Months **Funeral** 1□ M 2QF Yrs. BELARUS 90 214-35-9599 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County , or Itams 23a or 28a-f show 1 Yes 2 No BALTIMORE MD N/A the Funeral Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A 21215 3601 FORDS LANE #821 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (X) No If Yes, Give Year or Dates: 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or lian any injury or other traumatic event, Ita Mullical Expenses. 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify δ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGEMENT TYPIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SULPOVAR BASYA (UNKNOWN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26 IRONWOOD CIRCLE - BALTIMORE, MD 21209 LEONID AGRANOVICH / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CHIZUK AMUNO 2/22/2004 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signatur Junera Service Li 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one case on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Month in the past 12 months? ō 5 Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 212 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Sath 28b. Time of 28d. Describe how injury occurred After Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. Director: filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation in my opicion death occurred. within 24 hours a To the Funerel I 29a. Certifier Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 120/00 tenn ONIO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 Greene Tree Rd Pikes ville MD21208 enn 32. Prince Signature 31. Date filed (Month) State Registrar

		•	For State Registrar	State of Mary	land / Depa	artment of H	lealth and M Death	ne	g. 140.	
	Physicia		1. Decedent's Name (First, Middle, Last) Marie		S	streb		2. Date of Death Month	Day Yes	
>	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number) On HOSPI	tal		r Location of Death		4c. County of Di	
	Funeral Director		5. Social Security Number 6. Sex 217-07-4546		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 21	, 1909 Ma	Birthplace (State or Foreigh Country) ryland
	e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10	c.City, Town or Lo Baltimor					10d. Inside City Limits 1 □ Yes 2 □ No
	with th	I Dire	10e. Street and Number 5115 Hillburn Avenu	ue		10f. Zip Code 212	206	10	og. Citizen of What USA	Country?
336	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or items 23a or 28a-f show svent, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify: W	
21215-0036	e filed within 72 hou Il Hygiene. other than "natura vant, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired NUPSE	during most of work	ing	Mercy Hos	_
Maryland 2	should be filed ind Mental Hygi marked other umatic svant, I	To Be C	17. Father's Name (First, Middle, Last) George Henry Widma				18. Mother's Name	Baker		
Mar	s 1 and 2 should I Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type John Streb/Son	oe, Print)			and Number or Rur er Court (a, Zip Code) 1085
Baltimore,			20a. Method of Disposition 1 XBurial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	Nost Holy	osition (Name of matory or other place Redeemer	2/23	3/04 Ba	altimore	Maryland
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenses	· Christina	a L. Hilt	Dynme and Addre Leonar (5305 Ha	ss of Facility 1 J. Ruck arford Ro	Inc. ad Balt	imore Mar	yland 21214
68760,	death certificate be executed Medical Examiner Addition and Addition as as the burial-transit	licai Examiner	shock, or heart failure. List only or transediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	hock	Iryar	ction		Interval Between Onset and Death
P.O. Box 6	at the death certifica by the attending phatached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	(23d. Date of Month	delivery Day Year
	quires that n signed b uld be deta	by	Pan II. Other significant conditions con			nderlying cause giv	en in Part I.	23e. Did tob 1 ☐ Ye	44	o to the cause of death? Probably 4 □Unknown
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed	Diorbetes Hypo Hypor	dism				24a. Was ar autops perform 1 Yes 2	y prior	
Vital	ician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 Wo	lospital: 1 Ampatient	2 ER/Outpatie	nt 3 DOA Oth	26. Place of Deat		nce 6 Other (S	inacihe)
of	m 00	ation: To	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		f 28c. Injur Wor		28d. Describe ho		paciny)
Division	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm, st Specify)	reet, factory, office		28f. Location (Str City or Town		Rural Route Number,
	e Hospi 24 hou e Funer etely fill	Medicai		sician: To the best of m ner: On the basis of ex and manner stated	amination and/or in					
	To the within To the	Me	29b. Signature and title of certifier	(p	1	29c. Licens		29	ed. Date signed (M	
	Im		30. Name and address of person who co		h (Item 23a) (Type,	D. Carlo	6000	0.5	02/1	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Lack D	, Dann	were, 1	70 212	3 /
	Regist	rar	FFR 2.4 28	104 in institution	15 pm					

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 5:30a. /Medical Francine Thomas 02 8 2004 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Joseph Richey House Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M X(XF 52 219-52-4488 Director 51 07 06 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28e-f ahow other traumatic avant, the Madical Examinar must be notified at 1√ Yes 2 No Directo MD NA Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3708 Haywood Aye 21215 U.S.A.

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X X o If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 18 FEBRU 21215-0036 filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes ŽQNo Specity: Specify: Black ģ 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filled within 7. Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "ne any injury or other treumatic avant, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Mail Handler Postal Service na 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Franklin Wallace Jeanette Baskerville 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Parks-Mother 3708 Haywood Ave, Baltimore Md 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Murial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) King Memorial Park 2/21/04 Randallstown, Md 21. Sign ur of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Gliona with multiple Physician Intracranial 37 years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed signed by the attending physicien and d be detached for use as the burial-tran Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one INVATION Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ٩ 3 DOA To the Hospitel or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral di this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospitel o within 24 hours aft To the Funerel Di 1 © Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 02.18.2004 741476 V 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHAPLES ST; STE 416 , BALTIMORE 21204 MD RAYMOND W. WILSON MD. 31. Date filed (Month, Day, Year) 32. Register's Signature State FEB 2 4 2004 Missen & Specific Registrar

ORIGINAL

DHMH 17 Rev 1/2001

THOMAS

FRANCINE

DW

hysici		Decedent's Name (First, Middle, Last)	G8282 /27/ 04 EW <i>Ce</i>		12	Date of Death Month	Day Year	3. Time of Death
/Medic		Emma Trotter				rebourger	19, 2001	2:47 A
xamin		4a. Facility Name (If not institution, give street and i	number)	4b. City, Town, or Loca	ation of Death	/	4c. County of Death	n ,
		Northwest Hospital		Randal		Data of Dieth	Balto	
neral		5. Social Security Number 6. Sex 1	7. Age (In yrs. last birthday) 86 Yrs.		ours Min.	Date of Birth (Month, Day, Y	ear) 9. Birth	nplace (State or Fore untry) N . C .
ector		Usual Residence of Decedent	00			9 / 13	17	N·C·
E OM		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Lin
III III	cto	Md N/A	Baltimo	ore				1 X Yes 2 □
01.28	Dire	10e. Street and Number		10f. Zip Code			. Citizen of What Cou	untry?
8 238	ra	3834 Dolfield Avenu		21215	nia Origina /Canail		S A	ican Indian
Item Let	Funeral Director	Armed	ecedent Ever in U.S. 13. Forces? s 2 🔯 No	Was Decedent of Hispar If Yes, specify Cuban, Mo	exican, Puerto Ric	an, etc.)	Black, White	
o E	by F	If Yes,	Give r Dates:	1 ☐ Yes 2 ☑ No Sp	pecify:		Specify:	Black
Sea E		15. Decedent's Education		edent's Usual Occupation a kind of work done during	a most of working	16	b. Kind of Business/I	ndustry
- H	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) College	ife.	DO NOT use retired)	g most or working		Oriole	Resturar
rother than "vent, It's Ma	S	9th grade	N/A	Cook	Adam arta Maria a //	Time Adjusted Adv	idaa ()	
even	Be	17. Father's Name (First, Middle, Last) Robert Ledbetter			Mother's Name (F		den Sumame)	
Is marked raumatic ev	ဥ	19a. Informant's Name/Relationship (Type, Print)	19h Maili	ing Address (Street and I			ity or Town State Z	in Code)
traun		Charles Ledbetter - Se		116 Oakford				
: if item 27 is marked other than "natural, or items 238 or 28s is snow or other traumatic event, it a Madical Examiner must be notified at		20a. Method of Disposition	20b. Place of Dispo	osition (Name of ematory or other place)	Date	20	c. Location - City or 1	Town, State
7 or 1		1XXBurial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	m State	Star Cem	2/23/	2004 C	atonsvill	e, Md
Important: If its any injury or o once.		21. Signature of Funeral Service Licenses	2:	22. Name and Address of		ch F/H	West	21
any ii		Lebecs C. C.	50		4300	Wabash	Avenue B	alto, MD
hysician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events c.	to (or as a consequence of): to (or as a consequence of):					
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by the attending phy ached for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 It yes, 23c. If yes, 4 Pre	egnant at time of death 5[known	Other (specify)	Part I.		cco use contribute to	
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	1	For State Registrar	State of Mary	land / Dep		Health and N	Mental Hygi	ene g. No. 2004	05800
Physician		1. Decedent's Name (First, Middle, La	sy Thom,	95 54.			2. Date of Death Month Rbruary	Day Yeer /9 2004	3. Time of Death
/Medica Examine	7	4a. Facility Name (If not institution, gir	Baltmore			or Location of Death	-	4c. County of Death	111
Funeral Director		21/24 9050	Sex 7. Age (Ir	yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, FEB 26	Year) 9. Birtl	nplace (State or Foreign untry)
death with the Maryland	-	Usuel Residence of Decedent 10a. State 10b. County	10	c. City, Town or La	to rule				10d. Inside City Limits Yes 2 □ No
with the	2 /	10e. Street and Number	Ace	10 1	10f. Zip Code	, , _	10	g. Citizen of What Co	untry?
	by ruilera	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 12 Yes 2 No.A If Yes, Give Year or Dates:	Overno		Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
	Indicient	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	16a. Dece (Give	1	pation during most of world)	king	6b. Kind of Business/	
N BEE	מ	11 TE Grade 17. Father's Name (First, Middle, Las BEUTEN Ly THOMA		Stech	Women	18. Mother's Nam	ne (First, Middle, M		, 0/86/
e, Maryland 1 and 2 should be fit Health and Mental H m 27 is marked oth that traumatic even		19a. Informant Name/Relationship	Type, Print) S / Will	2830	8 Orleto	and Number or Rus	ral Route Number,	City or Town, State, Z	V-1
Ancort Kill Baltimore, North Baltimore, North Bealth Department of Health Important: If then 27 any injury or other transition of the strength		20a. Method of Disposition 1 Durial 2 Cremation 3 S 4 Donation 5 Other (Special Service)	fy)	ANVISO 2		U. A. Con ess of Facility Els TEN	AMMIN-		. 0 .
Physician		23a. Part1. Enter the disease, or cor shoot, or heart failure. List only Immediate Cause (Final	one cause on each line.		ter the mode of dyi	ng, such as cardiad			Approximate Interval Between Onset and Death
/Medical Examiner	Evaluate	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	b. Due to (or as a co	ation	preui	nonia ble Bre	nchoses	nic Ca	1 day
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Division of Vital Records, P.O. Box 68760, Hospitel or Attending Physician: The law requires that the death certificate be e. 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician telly filled in by the funeral director, page 2 should be detached for use as the burial director.	iysiciarymed	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim- 9 ☐ Unknown	Fetel death 3	⊒Ectopic pregnanc	у		23d. Date of deli Month	very Day Year
cords, P.O.	ed by rr	Part II. Other significant conditions Stroke 199	- 1	ot resulting in the c		ven in Part I.		acco use contribute to	the cause of death?
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Vita	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 KNo	Hospital:	2 ☐ ER/Outpatie	at 3 DOA Ot	har	th (Check only one	nce 6 Other (Spec	366
Division of Vital Records, To the Hospitel or Attending Physicien: The law requires th within 24 hours after death. To the Funerel Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be d	Certification; 10	27. Manner of Death 1 2 Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Ye	28b. Time o	of 28c. Inju		28d. Describe hov		ary)
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he Hospi n 24 houn he Funer bletely fills	Medical	29a. Certifier Certifying P	hysician: To the best of m miner: On the basis of ex- and manner stated	amination and/or in	th occurred at the to	me, date and place, opinion, death occur	, and due to the cau rred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
To the within 2 To the complete	2	29b. Signature and title of certifier	h	up	00400000	se number		d. Date signed (Month b: USIY 19	_
5		30. Name and address of person who	MD. Sinai	HOSPIT	Print) Fal of Bu	altimore	2		
State Registra	-	31. Date filed (Month-Day, Year)	32. Registrar's	Signature	A. N.				
DHMH 17 Rev 1/200	1	or they have full the	frag the	ORIGIN	IAL				

			For State Registrar	State of Marylar		artment of		Mental Hy	giene	/ 11 11 11	05801
	Physici		Decedent's Name (First, Middle, Last)	Searle W.	VonDo			2. Date of De Month			3. Time of Death
	/Medic Examin Funeral Director	er	5. Social Security Number 6. Se 186-01-2689	RE HOSPIT		4b. City, Town ROS If Under 1 Ye Months Da	ar If Under 24 H	ath	4c.	County of Death	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7
	faryland show	or	Usual Residence of Decedent 10a. State 10b. County MD Balti		ty, Town or Lo	ocation	Bal	timore			10d. Inside City Limits 1 ☐ Yes 2€ No
	death with the Maryland ms 23s or 28s-f show rmat be notified at	Director	10e. Street and Number 4215 Overton			10f. Zip Cod			10g. Citi.	zen of What Cou	ntry?
920	urs after death w	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		Was Decedent If Yes, specify 0 1 ☐ Yes 2 ☑ 1	of Hispanic Origin? Juban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	D-	14. Race - Ameri Black, White, SpecifWhi	etc.
21215-0036	be filed within 72 hours after ital Hygiene. d other than "natural", or ite event, tre Medical Examine	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation fe completed) College (1-4or 5+) 4	(Give	DO NOT use re	ne during most of w			Gover	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	To Be C	17. Father's Name (First, Middle, Last) ERnest VonDoh	ıln			Minni	ame (First, Middle e Parro	t	,	
	s 1 and 2 should ! Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship (T) Patricia Bryant				eet and Number or I				Code)
Baltimore,	permit. Pages 1 and 2. Department of Health an Important: If item 27 is any injury or other traignes.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)	Removal from State	cemetery, crer	sition (Name of matory or other sofFait	place)	Date 26/04		cation - City or T	
Balti	permit. Departrimports any inju		21. Signature of Funeral Service Licens	Onnell	22		dress of Facility C				neofEssex 21221
8760,	Physician /Medical Examiner physician and physician and physician and the prinal-transit	dical Examiner	shock, or heart failure. List only of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	A 1	quence of):		hmia Ascula	2 Dr.St	2 4 S (2	Interval Between Onset and Death
P.O. Box 68	that the death certifica ed by the attending ph detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1□Live birth 2□Feta 4□Pregnant at time of c	al death 3	Ectopic pregna Other (specify			2	3d. Date of deliv Month	ery Day Year
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D	Hospite 4 hours Funerel	edical Cer	29a. Certifier 154 Certifying Phy (Check only 2 Medical Exam)	sician: To the best of my kno	owledge, death	h occurred at the	e time, date and pla	ce, and due to the	cause(s)	and manner as s	a the equac(a)
5	within 24	Med	29b. Signature and title of certifier	and manner stated.		29c. Lic	ense number 05442	28	29d. Date	signed (Month,	Day, Year)
	Sta Registr		30. Name and address of person who compared to the second of the second	omple d cause of death (Iter 32. Registrar's Signi	m 23a) (Type. FRANK ature	Print) Llin S	QUARE	DR. BAI	Tim	ORE N	1d 21237

SEARLE VondonIN

State of Maryland / Department of Health and Mental Hygienes 05802 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician <u> Alfred E. Vernic</u> February 19. 2004 11:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Liberty Road Randallstown Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Days Director 220-20-2799 30, 1928 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Marylament of Health and Mental Hygiene.
ant: If Item 27 is marked other than "naturel", or Items 23e or 28e-fehov ury or other traumatic event, Ita Madical Examinar must be positived at tX Yes 2 No Director MD n/a Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 524 N. Charles Street #316 21201 United States Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Michael Vernic Anna M. Varara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Michael J. Vernie/brother</u> 5073 Marshfield Rd. Sarasota, Florida 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of h Important: if Ite any injury or of once. 02/26/2004 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, MD. 4 □Donation 5 □ Other (Specify) Dulaney Valley Mem. Grdn. 21. Signatury of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility S. Coster 1050 York Road Towson, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Finat disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisses or Injury) that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy ğ in the past 12 months? Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No detached 9 Unknown as been signed by 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 NO 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: Certification: To 1 Yes 2 N 2 ER/Outpatient 3 DOA 4 Nersing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by 4 Homicide filled Hospitel within 24 hours To the Funeral Cartifying Physician: To the best of my knowledge ideath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only ro the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21205 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05803 For State Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** WILLIAMS 1:20 P 20. THERESA February 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and num 4b. City, Town, or Location of Death Examiner 2309 Ailsa Avenue Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, APR 3, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months 1□M 2以F 72 218-28-8107 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d, Inside City Limits 10a. State or 28a-f show the Medical Examiner must be nutified at Yes 2 No Maryland N/A Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ітете 23а 2309 Ailsa Avenue 21214 USA death Funerai 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Marned 1 ☐ Yes 2 No If Yes, Give Year or Dates: 'natural', or Baltimore, Maryland 21215-0036 1 ☐ Yes 2♥ No Specify: White þ 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Physical Science Dept. Secretary University 12 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othen yinjury or other traumatic event Be John Ricci Bertha Mazzaruli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2309 Ailsa Avenue Terry A. Williams/Daughter Baltimore, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation
4 Donation 5 Other (5 3 Removal from State Other (Specify) Metro Crematory Inc. 2-21-04 Baltimore, MD 21. Signature of Furieral Service 22. Name and Address of Facility Cremation Society of 299 Frederick Road MD, Inc. Baltimore, of, Dawn F. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** IV S disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) sician and resulting in death) Last Due to (or as a consequence of) cate be by Physician/Medical attending IF FEMALE: cert 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery Bo 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Physician: The law requires that the death Month Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached the 9 Unknown Division of Vital Records, P.O. 9 Unknown δ signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 ☐ Yes 2 ☐ No 2[25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the 5 Pending investigation Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Within 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Signature and 29c. License number 29d. Date signed (Month. Dav. Year) 2 Oncolog 0056919 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert B. Donegan, MD 6569 N. Charles Street, Suite 205 West Towson, MD 21204 31. Date filed (Month) 32. Registrar's Signature State 4 2004 allion. Registrar

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			Please 1 - For State Registrar	State of Maryla	nd / Depa	artment o		Mental Hygi	_	4 05805
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ž	Examir		4a. Fecility Name (If not institution, give Carroll Hospital				wn, or Location of Dea estminster	th	4c. County of Dea	th
	Funeral Director		102 10 3373	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Y Months D	ear If Under 24 Hrs ays Hours Min		9. Bir 1923 NJ	thplace (State or Foreign ountry)
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	th with the 23e or 28	ai Director	10e. Street and Number 4115 Teklen	Drive		10f. Zip Co 2115			g. Citizen of What C	ountry?
036	should be filed within 72 hours after deeth with the Maryland of Menial Hyglene. Traturel, or iteme 23e or 28e-f ehow marked other then "naturel", or iteme 23e or 28e-f ehow imatic event, the Musical Exertiner Livial Le modified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		Was Decedent If Yes, specify 1 ☐ Yes 2 ☑	of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whi	te, etc.
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.		20a. Method of Disposition 1 □ Bunial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	Removal from State	Place of Dispo cemetery, crer 11y Hil	natory or other 1. Memo	place)	−O4; M	iddle Rive	er, Md
ñ	B T T T T		23a. Part 1. Enter the disease, or comp	-1	P.	U. BOX	195 Sykes	ville, Md	21784	Approximate
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•	To the To the comp	W	29b. Signature and title of certifier	-M/an	M	29c. Li	234798		d. Date signed (Monti	
2	λ		30. Namband address of person who of Robert Kass M	completed cause of death (Ite	m 23a) (Type,	Print)	yd #101	Wein	z-19-2 uster, MX) 21157
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrat's Sign 4 2004	ature	Small		00 00 mil	014/11	

		1	For State Registrar	State of Maryland	l / Departn <i>Certifi</i>	nent of Health and cate of Death	d Mental Hy	giene Reg. No.	2004	05806
	Physicia	in	Decedent's Name (First, Middle, Last) MILDRED	WOODS			2. Date of De Month FEBRUAR	Day	Year 3 2004	3. Time of Death 12:55 A M
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give s MARINER HEALTH O 5. Social Security Number 6. Sex	treet and number) F FOREST HILL	st birthday) If I	City, Town, or Location of D FOREST HILL Under 1 Year If Under 24 Inths Days Hours N	eath	4c. 0	HARFOF 9. Birth	
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	with the A 3a or 28a-1	Funeral Director	10e. Street and Number 3042 Rocks	Rd.		21080	1	10g. Citiz	en of What Cou	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Department of Heatin and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event. It a Madical Exact an intelligible at ponce.	by Funera		2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	It Yes	Decedent of Hispanic Origin , specify Cuban, Mexican, Pi res 2 No Specify:	? (Specify Yes or No uerto Rican, etc.)		4. Race - Ameri Black, White,	
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_	D		30. Name and address of person who co	~~ 6-5 W	MAC PI		mp			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** rebruary W12500 dwaro 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MOTE

If Under 24 Hrs.

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Month, Day, Benera 12 Maryland HOSD, tal 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days LEGM 2 F Months 62 5/32 50 Director marci Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at BALLIMOR Yes 2 □ No MArylow Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? # 106 , or Itams 23a or 21217 AVE USA MADISON 2601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use, retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other fraumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) SUNSELOV 46AYS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILSON CIV Apom An HISENIA 19a. Informant's Name/Relationship (Type, - nt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOT 182 WULIN HISENIU 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition → Burial 2 ☐ Cremation 3 ☐ Removal from State L. Zion * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sovice Licensee 22. Name and Address of Facility WA TEXTOUR 5240 REL ROMO BALLABRE Ac 212/5 a. Pa ./. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s .ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im ediate Cause (Final disease or condition resulting in death) Physician evere Inemi /Medical Due to (or, as a consequence of): Examiner ficiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ₺ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death Check onl. one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 1 Inpatient 3□ DOA To the Funeral Director: After th completely filled in by the funeral 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours after To the Funeral Dire To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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		1 - For State Registrar	State of	Marylan		artment of H		d Mental Hygi	ene 2	004	05808	3
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Examin	- 2	4e. Facility Name (If not institution, g.	ve street and numb	er)		4b. City, Town, or	Location of D	eath	4c. Count	ty of Death		
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Director		094-12-8723 Usual Residence of Decedent		01	113.			Aug. 21	1922	Cana	ada	-
and		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits	
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r 28a	irec	10e. Street and Number			-	10f. Zip Code		10	g. Citizen of	What Cour	ntry?	
h witi	Funeral Director	800 Southerly	Rd. #1412	2		2128	6			USA		_
dea	iner	11. Marital Status	12. Was Deced Armed Force	ent Ever in U. es?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin' n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		ace - Americ ack, White,		
or it		1 Never Married 2 Married	If Yes, Give			1 ☐ Yes 2 🗓 No	Specify:		Speci	ify:	White	
be filed within 72 hours after death with the Marylan ital Hygiene. do other than "natural", or Itams 23s or 28s-f show	d by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dat	es:	162 Docer	dent's Usual Occupa	ation	1	16b. Kind of I	Business/In	dustry	_
n 72	jete	(Specify only highest g	rade completed)		(Give	kind of work done of DO NOT use retired	during most of	working			,	
with iene. than	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)	Bookke				Educa	tion		
other snt,	0	17. Father's Name (First, Middle, La.	st)					Name (First, Middle, M		me)		
Ald be riked riked ticev	0.8	Charles R. Joh	nson				Glad	ys I. Fenne	essy			
2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene is marked other than "natural", or Itama 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship				-		r Rural Route Number,				d
and 2 salth n 27 i		Mr. C. Richard Wo	orking/ H			Contract to the second second second	y Rd.	#1412 Tows				j
of He		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3	□Removal from SI	0	emetery, crei	sition (Name of matory or other place			20c. Location	•		
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Dartillion of wat a permit. Pages 1 and 2 should be Department of Health and Mental important: If item 27 is marked any injury or other traumatic e once.		21. Signature of Funeral Service Lic	ensee		22	2. Name and Address	ws of Facility Fi	uneral Home Towson, Mc	, Ins	Δ4		1
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Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	0171	NE	178/11	M C-V	inge		1	SAKS	_
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ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Feta	Ideath 3	Ectopic pregnancy	,			ate of delive fonth	ory Day Year	1
the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9□Unknov	nt at time of d vn	eath 5	Other (specify)						
hat if	Ph	Part II. Dther significant conditions	contributing to dea	ith but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use co	ntribute to t	ne cause of death?	٦
signe d be	d by	•						1 □ Ye	s 2 🗆 No	3 🗆 Prob	ably 4 Unknown	
w requir s been si should l	Completed							24a. Was a	24h	Were auto	psy findings available	-
has ge 2 s	I d							autops perform	ned2	prior to co death?	mpletion of cause of	
n: Th	e Co	25. Was case referred to medical					26 Place of	1 ☐ Yes 2 Death (Check only on	No No	1 🗆 Yes	,20 No	_
on or vital ned ding Physician: The lav h. After this certificate has funeral director, page 2.	0 8	examiner?	Hospital: 1 🗆 In	patient 2	ER/Outpatie	nt 3 DOA Oth	or:	ng Home 5 ☐ Reside		ther (Specif	v)	
Phy Prhy er this	⊢	27. Manner of Death	28a. Date of		28b. Time o			28d. Describe ho				
Attanding rt death. actor: After by the fune	atio	1 Natural 5 Pending 2 Accident investigat		, Day 16al)	Injury		Yes 2 □No					
Atta acto by th	Certification:	3 Suicide 6 Could no 4 Homicide determine	ad 286. Place	of Injury - At hig, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location (St. City or Town		nber or Rura	I Route Number,	
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To the Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the the	edical	(Check only 2 Medical Ex	aminer: On the ba	sis of examina	wledge, deat ition and/or in	th occurred at the tire evestigation, in my o	me, date and p pinion, death	place, and due to the ca occurred at the time, da	iuse(s) and rate and place	manner as s e, and due to	tated. o the cause(s)	
thin 2 tha mplet	Med	29b. Signature and title of pertifier	and marin	r stated.		29c. Licens	e number	2	9d. Date sign	ned Month.	Dey, Year)	
7 × 00		A de de	111	1111	MO.	DO	122	65+	2	119	104	
B		30. Name and address of person w	no completed cause	of death (Iter	n 23a) (Tvna	Print)			1	. /	- 01-	_
		30. Name and address of person with the control of	eauss	M.D.		MBMC	6+6	11 N. C	nArelt	s S) DALLO	
St Regist	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ature	Roses						

			For State Registrar	State of Marylar	•	nt of Health and I		2001.	05809
	3		Registrar Decedent's Name (First, Middle, Las	t)	Oertineat	e or beari	2. Date of Death Month Da		3. Time of Death
\	Physicia /Medic		William Yi	ngling			Feb. 20	1 2004	2:09P.M
	Examin	er	4a. Fecility Name (If not institution, give	Advon tis	+ HOSO.	Rock Ville		County of Deeth	mery
÷2	Funeral Director		2101072101	7. Age (In yrs.	last birthday) If Under Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Blirtho	place (State or Foreign
	yland Iow at		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location			1	10d. Inside City Limits
	8a-1 st	ector	MD Worce	ster. C	Ocean (ity	100 0	itizen of What Cour	1 ☐ Yes 2 🕅 No
	3a or 2	Funeral Director	10e. Street and Number	of Doit 1	03	21842	109. 0	1)5 A	nuy r
	r death	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was Dece If Yes, spe	dent of Hispanic Origin? (S scrip Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
920	72 hours after death with the Maryland Insturat; or ttems 23a or 28a-f show dical Examiner must be neiffied at	ð	1 Never Married 280 Married 3 Widowed 4 Divorced	1 Yes 2 No fi ¥es, Give Year or Dates:	1 ☐ Yes	20 No Specify:		Specify: W	rite.
21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artiment of Heatilb and Mental Hygiene. ortant: if item 27 is marked other than "natural; or items 23a or 28a-1 show injury or other traumatic svent, it a Medical Examination and injury or other traumatic svent, it a Medical Examination.	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decedent's Usu (Give kind of w	ork done during most of wor		Cind of Business/In-	dustry
212	giene. er then "	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Pastor	136 / 161/180/	1	therar	- Church
	be filed ital Hygi d other svent, I	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, Maide	n Sumame)	į.
Maryland	should nd Men marke imaric	2	19a Informant's Name/Relations ip ($(A \cup A \cup A \cup A \cup A \cup A \cup A \cup A \cup A \cup A \cup$	19b. Mailing Addres	s (Street and Number or Ru	LI MM CI	or Town, State, Zir	Coder 21847
Ma	and 2 sho ealth and n 27 is m		Ruth E. Vir	alina	10 564	Street. U	ni+ 103 1	Ocean (City MD
ore,	jes 1 and of Health if item 27 or other tr		20a. Mathod of Disposition 1		Place of Disposition (Na cemetery, crematory or	me of other place)	Date 20c. L	ocation - City or To	own, State
Baltimore,	permit. Pages Department of I Important: If its any injury or of		*4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	n St.	John's Ev. 1	uth (h (em 2)	1-26-04 P	ARKVIII	11 211
Ba	permit. Departr Importe sny inju		Kinberley) Ravides	3 EVAN	SFUNERAL	CHAPEL 8	800 HAR	FORDRO
24	§ y		23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caused the dea	th Do not enter the mo	de of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Septic Due to (or as a consec	Shock				
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oʻ	be executed sician and buriat-transit	Examin	that initiated events resulting in death) Last	Due to (or as a consec	quence of):				
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Box 6	leath certificat attending phy I for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1☐Live birth 2☐Feta		oregoancy	WALK VI.	23d. Date of delive	
.O. B	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as It	Physiclan/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant at time of o				Month	Day Year
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Records,	w require been sig should b						1		bably 4 Unknown
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Vital		9	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2 Ø No ath (Check only one)	o 1 ☐ Yes	2 No
fVi	S D	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐ D	OA Other: 4 Nursing H	lome 5 Residence	6 ☐Other (Specif	6/)
on of	ing After une		27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju		
Division	ten leat tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		nome, farm, street, facto		28f. Location (Street a City or Town, Stat	nd Number or Rura e)	al Route Number,
Į.	Hospita 4 hours Funeral ely filled	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exer	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place n, in my opinion, death occu	e, and due to the cause(s arred at the time, date an	s) and manner as s ad place, and due to	tated. o the cause(s)
	To the I	Me	29b. Signature and title of certifier		29	9c. License number	29d. Da	ate signed (Month,	Day, Year)
į.	λ,		Aloshu	M.D.	- 22a) (Tara - 23a)	060557	Febru	eary 22,	2004
	γ,		30. Name and address of person who DR. LEO SHUE	completed cause of death (Ite	edical Ce	060557 nter Dr.	Rockvill	e, mb	20850.
9	St:		31. Date filed (Month, Day, Year)	2004 32. Registrar's Sign	nature A Acad	R)			

		_	1 - For State Registrar	State of Mary	land / Dep <i>Ce</i>	ertificate of	lealth and M Death	Re	g. No.		
	Physici /Medio		1. Decedent's Name (First, Middle, Last Charles	Bell		Adams		2. Date of Death Month Februar	y 21 2004	3. Time of Death	
- X	Examin Funeral Director	S. C.	4a. Fecility Name (If not institution, give Anne Arundel Medi 5. Social Security Number 6. Se 219-32-3320	cal Center	yrs. last birthday Yrs.	Anna	apolis If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 1,	4c. County of Deat Anne A year) 1935 Mar		
5	D		Usuel Residence of Decedent 10a. State 10b. County MD Anne Aru	100	City, Town or t			July 19	1733 Har	10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	ath with the I 23a or 28a- nut be notif	rai Director	10e. Street and Number 1277 Ritchie High	way, Unit 2	00	10f. Zip Code 210			Og. Citizen of What Co		
960	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or iteme 23a or 28a-1 ehow ent, the Medical Exacting remail be institled at	d by Funerai	11. Marital Status 1 □ Never Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2XXVo If Yes, Give Year or Dates:	in U.S. 13	I. Was Decedent of H If Yes, specify Cub 1 Yes 2XXNo	dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
21215-0036	d within 72 ho piene. r than "natu rre Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12		(Giv life.	edent's Usual Occup re kind of work done DO NOT use retire mic Tile (during most of work d)	ing	16b. Kind of Business/ Constructi	·	
Maryland 2	ould be filed Mental Hyg karked other katic event,	To Be C	17. Father's Name (First, Middle, Last) Arthur Leroy Adam					Taylor			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Iteme 23s or 28s-f show any injury or other traumatic event, the Medical Evant at must be neithed at ance.		19a. Informant's Name/Relationship (T) Virgie A. Adams (20a. Method of Disposition 1 Burial 2006 remation 3 DI	Wife) Removal from State	127 Ob. Place of Disp cemetery, cri	7 Ritchie position (Name of ematory or other place	Hwy, Uni	t 200, An	City or Town, State, 2 rnold, MD 20c. Location - City or	21012	
Baltimore,	permit. Pag Department Important: any injury once.		4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licenty)	fre-		rematory Hardesty 12 Ridge	ss of Facility Funeral	Home, P	Baltimore, .A. olis, MD 2		
	Physician /Medical Examiner		23a. Pert 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the ne cause on each line. a Due to (or as a content of the cause of the caus	Myou		ng, such as cardiac	or respiratory arre		Approximate Interval Between Onset and Death	
68760,	icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cool Due to (or as a cool d.							
P.O. Box 68	res that the death certificat igned by the atlending phy be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yas, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	B⊟Ectopic pregnanc □ Other (specify)	у		23d. Date of del Month	ivery Day Year	
	w requires that been signed to should be deta	Ď	Part II. Other significant conditions of	entributing to death but no	t resulting in the	underlying cause giv	ven in Part I.		acco use contribute to		
al Records,	ysicien: The law r is certificate has be director, page 2 sh	Completed							prior to death?	atopsy findings available completion of cause of 2 No	
Division of Vital	ng Ph Iter th Ineral	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	215 ER/Outpati 28b. Time Injury	of 28c. Injury	f 28c. Injury at Work? 28d. Describe how injury occurred				
Divis	To the Hospital or Attending Phyminin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S		street, factory, office		28f. Location (Str City or Town	reet and Number or Re , State)	ural Route Number,	
	o the Hosp rithin 24 hou o the Fune ompletely fil	Medicai	29a. Certifier (Check only one) Certifying Physical Example (Check only one)	ysician: To the best of mainer: On the basis of exa and manner stated.	mination and/or	investigation, in my	pinion, death occur	red at the time, da	ate and place, and due	to the cause(s)	
)	^h		30. Name and a dress of person who d	where M	(Item 23a) (Type	e, Print)	32036	,	2/22/01	(
	Sta Regist		31. Date filed (North, Ogy, Jean 0) 4	1 JJ 2 - Applistrar's	Mature 13	DWinto D	rive Cr	121 He-, V	9d. Date signed (Mont. 2/21/01	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 L For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 5. Social Security Number Date of Birth (Month, Day 7. Age (In yrs. last birthday) 9 Birthplace (State or Foreign Country) **Funeral** 2∏ F Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Ikem 27 is marked other than "naturel", or Iken eny injury or other traumatic event 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life, DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suntame) Be ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bulal Route Number, City or Town, State, Zip Code) 19Ho) 22H YC 20b. Place of Disposition (Name 20a, Method of Disposition Date 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State * 4 ☐ Donation 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Woughn Funeral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Medical Certification; To Be Completed by Physician/Medical as the 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 2 | No 4 DUnknown 24a. Was en autopsy performed 1 Yes 2 V 24b. Were autopsy findings available prior to completion of cause of death? in by the funeral director, page 2 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only or Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛛 No 1 🗌 Yes 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funerel Director: After 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) me and address death (Item 23a) (Type, Print) 31. Date filed (Month 32. State 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 7:25 PM **Physician** sbruary 2004 Karen Armstrong /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of Maryland Medicil Center Baltimore (Iniversity N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 StF 49 Yrs. Director Sep 25, 1954 Maryland 213-62-8901 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
and it if item 22 is marked other then "naturel", or Itema 23e or 28a-1 show and it if item or other traumatic event, ite Medical Examination count or other traumatic event, ite Medical Examination of the statement of the Medical Examination of the statement of the Medical Examination of the statement of the Medical Examination of the statement of the Medical Examination of the Medical Examinat 1 ¥ Yes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 United States 172 West Hamburg Street Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify. 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Armstrong Ruth Ellen Garrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Machael Armstrong-Cousin 172 West Hambury Street, Baltimore, MD 21230 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Feb 25 permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) Mount Zion Cemetery 22. Name and Address of Facility Baltimore, MD 2004 21. Signature of Funeral Service License a Com Z. a Calvin L. Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore MD

Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1emia /Medical Due to (or as a consequence of): we pulonowary **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed anding physician and use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed t Part IJ, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 🗆 No certificate 1 Yes 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: 1 patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After the Hospital or Attending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🚾 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signalura and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gleene Street Baltmare, MD 21201 Keshamwalg 22 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 5

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

FFR 2 5 2004

Anderson

P.O.

			For State Registrar	State of Marylan	d / Departme <i>Certifica</i>	ent of H ate of	lealth and N Death	fentai Hy	giene Reg. No.	2004	05814
			1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Mary L.	Adams				Februa	ry Ź	2 2004	8:00 A ^M
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. Ci	ity, Town, o	recation of Death		4c.	County of Deeth	
			NORTH HRUNDEL	HOSPITAL.	C_{2}	en [der 1 Year	If Under 24 Hrs.	Day of Bin		NUTF	TRumel
	Funeral		5. Social Security Number 6. Sex 10	7. Age (In yrs. 71	Month		Hours Min.	8. Date of Bir (Month, De NOV. 2	y Year)	32	nplace (State or Foreign untry) MD
	Director		Usuel Residence of Decedent	/			J	NOV. Z	3 13	32	עויו
	land ow		10a. State 10b. County	10c. Cit	y, Town or Location						10d. Inside City Limits
	Man First	ţō	Maryland Anne Ar	undel		Pasa	dena				1 □ Yes 2 No
	death with the Maryland ms 23a or 28a-f show fritual be notified at	Directo	10e. Street and Number		10f.	Zip Code			10g. Citi	izen of What Co	untry?
-1	th wit		8157 Orchard Poin	t Road			21122			USA	
0	ems	Funeral	Tr. Maritar States	Was Decedent Ever in U Armed Forces?	.S. 13. Was De If Yes, s	cedent of H specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.))-	 Race - Amer Black, White 	
>0	or it	by Fu	1 □ Never Married 2 ☑ Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 □ Yes	s 2⊠ No	Specify:			Specify: W	hite
78	hours after tural', or ite		3 Widowed 4 Divorced	Year or Dates:	16a. Decedent's U	Isual Occur	nation		16b K	ind of Business/l	ndustry
15-	n 72	Completed	(Specify only highest grade	completed)	(Give kind of life. DO NO	work done	during most of work	king			
512	withi iene. than	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Homema	ker				House	hold
9	Hyg her other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle	Maiden	Sumame)	
<u>_</u> E	lid be lenta rked	To B	Robert Mulle	n			Ruth	Pey	ton		
ADAMS Maryland 212	shou and M s mai		19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailing Addr	ess (Street	and Number or Ru	ral Route Numb	er, City c	r Town, State, Z	(ip Code)
EZ	and 2 halth a 1 27 i		Billy W. Adams Sr				Point R.				
A	of He of He liter		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ R		Place of Disposition (a cemetery, crematory of	Name of or other pla		Date 26		cation - City or	
PE	Page nent ant: K		*4 □Donation 5 □ Other (Specify)	Mar	ryland Vet	erans	Cem. 2	004	Cro	wnsvill	e, Maryland
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Meutoal Exament must be notified at once.		21. Signature of Funeral Service Libert	ee e			ess of Facility ntain Roa				Home, P.A.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deal	th. Do not enter the n	node of dyl	ng, such as cardiac	or respiratory a	rrest.	, 110 - 61	Approximate Interval Between
	Physician		Immediate Cause (Final	CORONAR			DISEARG				Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consec							
	Examiner		Constants the time conditions								
	2 2	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury)	Due to (or as a consec	quence of):						
	cate be executed obysicien and the burial-transit	Examlner	that initiated events								
ó,	be execuicien and	Ä	resulting in death) Last	Due to (or as a consec	quence of):						
8760,	ate b	dica		l							
9	The law requires that the death certificate te has been signed by the attending physicage 2 should be detached for use as the	Physician/Medical	IF FEMALE:	3c. If yes, outcome of pregn	anov					Dod Date of dell	
Box	ath catternate attend	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 □Ectopi	c pregnanc	у			23d. Date of deli Month	Day Year
	the a	yslc	1 Yes 2 No	9☐ Unknown	164(II) 2 O O (II) 61	(spacity) _			101		
P.0	that the deed by the	Ph	Part II, Other significant conditions con	ntributing to death but not res	sulting in the underlying	ng cause gr	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
of Vital Records,	signed d be del	d by						1 🗆	Yes 2	□No 3□Pr	obably 4 donknown
ö	w require been si should?	Completed						24a. Was	an	24b. Were au	itopsy findings available
ě	The law ate has page 2	E							ormed?	prior to death?	completion of cause of
a		e Co	25. Was case referred to medical				26. Place of Dea	1 Yes	2(2/No	1 Yes	2 No
2	ysician: is certific director,	8	evaminer?	Hospital: 1 PInpatient 2	ER/Outpatient 3	DOA Ott	hor			6 □Other (Spec	cufy)
ō	Attending Physician: r death. ector: After this certifics by the funeral director,	.: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inju	ry at	28d. Describe			ony/
8 6	th. : After s funer	ig i	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	1 [Yes 2 No				
Division	Attendi r death. ector: A by the fu	if	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fac	ctory, office		28f. Location (ıral Route Number,
Ö	spital or Attending lours after death. eral Director: After filled in by the funer	Certification:	4 ETHORNEGO	building, oto. (Open						·/	
	e Hospital or Atten 24 hours after deatl e Funeral Director: etely filled in by the	edical (29a. Certifier Certifying Phy (Check only one)	sician: To the best of my kn ner: On the basis of examinand manner stated.	owledge, death occur ation and/or investiga	red at the ti	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s date an) and manner as d place, and due	stated. to the cause(s)
	To the Hos within 24 ho To the Func completely f	Mec	29b. Signature and title of certifier			29c. Licen	se number		29d. Da	te signed (Monta	h, Day, Year)
	F 3 F ŏ		bull boss	ahun "	MA	100	55973		FEB.	RUARY	22,2004
•	h		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, Print)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	/ /				
			ZELEKE DESSE 1	1500 SUTHER	LAND HIL	LNA	4 SILVE	R SPRIN	UCA	MD	20904
		ate	31. Date filed (Month, Day, Year)	ompleted cause of death (Ite / 5 CO SUTHER 32. Registrar's Sign	ature Louis	2/					
	Regist	rar		meder	person or contract	-					

State of Maryland / Department of Health and Mental Hygiene 2001 05815 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Feb 19, 2004 Year 4:40 Am. M **Ernestine Battle** Physician /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore** Timonium Stella Maris (Dulaney Valley) 7. Age (In yrs. last birthday)

64 Yrs.

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug 29, 1939 9. Birthplace (State or Foreign 5 Social Security Number **Funeral** 1 ☐ M 2 🔀 F South Carolina 217-34-3036 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a State ral', or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Baltimore N/A Maryland Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number U.S.A. 21218 2811 The Alameda Funeral death 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married within 72 hours after Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Nivorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hedwin Corp. t of Health and Mental Hygiene. than College (1-4or 5+) Elementary/Secondary (0-12) Machine Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Lee Knox Henry Horton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 293 S. Spring Ct. Baltimore, Maryland 21231 Rosa Lee Knox 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If its any injury or ot 1 Paurial 2 Cremation 3 Removal from State 02/23/04 Randallstown, Maryland King's Memorial Park * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** BLADDER CANCER resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 0 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes *2 ☐ No certificate 1 ☐ Yes 2 X No Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 1 ☐ Yes 2 😿 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA ot 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Division 1 XNatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: 6 Could not be 28I. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year) FEB 2 5 2004 32. Agistrar's Signature State Registrar

FEBRUARY 19,

ERNESTINE

			For State Registrar	State of Mar		artment of H		-	ene 200	4 05816
	Physici /Medio	al	Decedent's Name (First, Middle, Last) Rose		B	rowner		2. Date of Death Month February	Day Year	4 01-31PM
	Examir Funeral	er	4a. Facility Name (If not institution, give Harbor Hospit 5. Social Security Number 6. Sep	al center	(In yrs. last birthday)	4b. City, Town, or Botton If Under 1 Year Months Days		- 8 Date of Birth	4c. County of De	N/A
	Director)r	Usual Residence of Decedent 10a. State 10b. County		63 Yrs.	ocation	n Burnie	(Month, Day, Dec 8,	1940	Maryland 10d. Inside City Limits 1 Yes 2 No
7	h with the M 3a or 28a-f	al Director	Maryland Anne A 10e. Street and Number 115 Warwickshire Lane A			10f. Zip Code	21061	10	g. Citizen of What (
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natureli", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Evant and the notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☐ Who	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wr Specify:	nerican Indian, nite, etc. Black
Maryland 21215-0036	within 72 hou ene. than "nature he Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired, Troub	uring most of wo	rking	Sb. Kind of Busines	s/Industry A. (State)
yland 2	ould be filed Mental Hygis arked other atic event, 1	To Be Co	12 17. Father's Name (First, Middle, Last) James	•					na Dorsey	
re, Mar	t and 2 she Health and tem 27 is mother traum		19a. Informant's Name/Relationship (Ty Harold Browner Son 20a. Method of Disposition	pe, Print)	20b. Place of Dispo	15 Warwicksh	nire Lane Ap	ural Route Number, ot#L Glen Burr Date 2		21061
Baltimore,	smit, Pages epartment of sportant: If i ny injury or one		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Fun (a) Service License	- A	Fairvie	w U.M. Church	Cem.	02/27/04 neral Home P./		le , Maryland
	Prysician /Medical Examiner		23a. Part1. Enter the disease, or compleshock, or hear failure. List only or immediate Cause (Final disease or condition resulting in death)			1300 Ei	utaw Place , such as cardia	Baltimore, MD c or respiratory arres	21217	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a d	consequence of):	cell lun	ng Car	nces		Z Years
.O. Box 6	he death certific r the attending p ched for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	elivery Day Year
۵.	w requires that the de been signed by the should be detached	ed by Ph	Part II. Other significant conditions con		23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown					
al Reco		Completed						24a. Was an autopsy perform 1 Yes 24	prior to death?	autopsy findings available completion of cause of es 2 \sum No
Division of Vital Records,	ding Phys T. After this funeral dir	tion; To Be	27. Manner of Death 1 🗷 Natural 5 🗆 Pending	1 ⊠Inpatient 28a. Date of Injury (Month, Day)	28b. Time o	of 28c. Injury Work	^{or:} 4 □ Nursing H	ath (Check only one) Home 5 Residen 28d. Describe how		ecify)
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)			28f. Location (Stre City or Town,		Rural Route Number,
	the Hospi in 24 hou the Funer upletely fill	Medical	(Check only 2 Medical Exami one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or in		inion, death occu	urred at the time, dat	e and place, and du	ue to the cause(s)
)	V With	-	29b. Signature and title of certifier	5 CF	2eM	D. RE	S OO I		Date signed (Mor	23; 2004
	11		30. Name and address of person who co Tan Min Chen 31. Date filed (Month, Day, Year)	32. Pagistrar	outh H	anover	St. E	Baltimor	e MD	21225
	Sta Regist		FEB 2 5 20	95"	Le Sa	perte				

State of Maryland / Department of Health and Mental Hygiene 2004 05817 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 6:00 AM **Physician** Brown /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Battimore Rehabilitation Extended Cave Center BALTIMORE

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) NIA 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 7-38-1636 AUG 26,194. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show event, the Mudical Execute armust be notified at 1 Yes 2 No Directo MARYLAND 10g. Citizen of What Country? 10e. Street and Number 5 1030 Itema 23a Funeral 0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever n U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Item eny injury or other traumatic. 1 MYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CARRIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ASHLEY 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nam elationship (Type, Print) FALLS WAY COCKEYS VILLE MD 21030
of place)

Date abc. Location - City or Town, State (DAUGHTER) WINDY ANE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 02-27-04 OWINGS MILLS, * 4 ☐ Donation 5 ☐ Other (Specify) FOREST 22. Name and Address of Facility BROWN AVE., JR. FUNERAL HOME 21. Signature of Funeral Service Licensee BROWNS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Talluve **Physician** len a /Medical Due to (or as a consequence of): **Examiner** ancer Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit abetes The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, ed bluods 4 Unknown 3 Probably Be Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? (es 2 No 1 TYes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3 DOA Medical Certification; To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) D41365 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 21, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Loch Raven Boulevard, Battinove, MD. 21218 ICKS VU 31. Date filed (Month, Day, Year) 32. Registre's Signature State 2 5 2004 ▶ Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 6:45 AM BURD 2004 **Physician** & KUE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 8. Date of Birth (Month, Day, Year) owson CARE 10WSON MANOR if Under 1 Year If Under 24 Hrs.
Months Days Hours Min 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number MA **Funeral** 1 🗆 M 214-16-8584 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c City Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.

ant: If item 27 is marked other then "natural", or iteme 23a or 28a-f show ury or other traumatic event, the Medical Exattr set must be notified. 1 Yes 2 No BALTIMORE hOENIX Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A RA 2113 by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: LuhiTE Specify: Baltimore, Maryland 21215-0036 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10001 ACCOUNTANT 12-46 Ala 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FANNIE KNODE JONASS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ELMO CT APPI 101 Cockeysville, MD 2 1030 BAUGHER PERRILL 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages Department of Important: If it eny injury or o OwinGS Mills, MD. 04 GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) FUNERAL HOME CHTD. 22. Name and Address of Facility Stell + 21. Signature of Funeral Service Licenses BA Ito. MO harFord RD 7527 23a. Part . Enter the disease, or complications that cause, the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each link Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician nsequence /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to for as a P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2□ No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? the funeral Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide completely filled in by 4 Homicide 12 Certifying Physician: To the best of my knewledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/of investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mayner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifie stuse of with (Item 23a) (Type, Print) 7600 Os 10050 n ler-

DHMH 17 Rev 1/2001

State Registrar Year)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 200405819 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 949 Physician KATHY MAE BENTON February 20, 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rosedale

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Franklin SQUARE HOSDITAL Timore 8. Date of Birth (Month, Day. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Maryland 6 Sex 5. Social Security Number **Funeral** 46 June 24–1957 1 ☐ M 2**X** F 213-66-7055 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10b. County or 28a-f ehow the Medical Examiner must be notified at Baltimore County 1 Yes 2/3(No Baltimore Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10631 Bird River Rd. 21220 USA "netural", or itams 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes X No Specify: White Specify: ģ 3 Widowed XX Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12th grade than. Clerical J.B.A. Chevrolet permit. Pages 1 and 2 should be filled Department of Health and Mental Hygis Important: if Item 27 is marked other any injury or other traumatic avent. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Roesner Margaret Seitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11724 Hamilton Place White Marsh, Md. 21162 Glenn Ernest Roesner Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem: 2-24-04 Baltimore, Md. 21. Signature of Funeral Service Licensee ^{22. Nam}Lassann of Funeral Home Lassakn 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Preumonia Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day detached for in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 TYes 2 🗆 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1 Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Mary er of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident in by the Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Res 00000 0 who completed cause of death (Item 23a) (Type, Print) -9000 Drive - BALTIMORE Franklin 32. Registrar's Signature 3 2 5 2004 State

DHMH 17 Rev 1/2001

Registrar

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		,	1 - For State Registrar	State of Mar	yland / [Departme <i>Certifica</i>	nt of He	ealth and Death	Mental Hy	giene Reg. No.	2004	058	20
	Physicia	an.	Decedent's Name (First, Middle, Li				_		2. Date of De		Year	3. Time of Dea	th
	/Medic		CARL	JOSEPH	BAL	JER	JR.		FEBRUAR		,2004	4:05 A	М
	Examin	er	4a. Facility Name (If not institution, gi			4b. Cit		_ocation of De	eath		County of Death		
20			404 E. CLEMENT 5. Social Security Number 6.		In yrs. last bir	rthday) If Unc	BAL I	IMORE	Irs. 8. Date of Bir		N/A	place (State or For	reian
	Funeral Director			1 □ M 2 □ F		Yrs. Month		Hours M	in. (Month, Da	ıy, Year)	Cou	intry)	oigi i
			Usual Residence of Decedent						Dec. 2	4 192	4 ⊥Mary	land	
	how		10a. State 10b. County		Oc. City, Tow	m or Location altimor	0					10d. Inside City Lin	
	Ba-f a	cto	Md. n/	a	,رر	altimor						1 (X) Yes 2 [No
	filed within 72 hours after death with the Maryland Hygiene, then "neturel", or items 23e or 28e-f show ent, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 404 E. Clement	Street		10f. 2	Zip Code 21	1230			en of What Cou J.S.A.	intry?	
	ns 23	eral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was Dec	edent of His	panic Origin?	(Specify Yes or No)- 1	4. Race - Amer	can Indian,	-
	or itan	Fun	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 May Yes 2 No					(Specify Yes or No lerto Rican, etc.)	1	Black, White		
2	ral', c	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 L Yes	2XNo	Specify:			Specify: WD	ite	
5	netu dice	ete	15. Decedent's E (Specify only highest gi	ducation ade com <i>pleted)</i>	16a.	Give kind of v	sual Occupat work done du	ion <i>iring</i> most of v	working	16b. Kin	d of Business/Ir	ndustry	
7	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	S	ervice				Α.	D.T.		
2	Hygin Hygin ent.	Be Co	17. Father's Name (First, Middle, Las	")			1	18. Mother's N	lame (First, Middle				
0	should be filed with nd Mental Hygiene. marked other than imatic event, the N	To B	Carl J.	Bauer Sr.				Anna	Fer	gusor	1		
	E E		19a. Informant's Name/Relationship	(Type, Print) (Wife)					Rural Route Numb				
ຂ ນົ	permit. Pages 1 and 2 Department of Health a Important: if Item 27 it eny injury or other tra once.		Dolores E. Bauer 20a Method of Disposition	(wire)	20b. Place of	f Disposition (A	ame of		Date Date		ation - City or T		
DAILIIIIO	ages ant of t: # lt y or o		1 Burial 2 Cremation 3 (Removal from State	cemete	ry, crematory o .ew Creп	r other place,		/24/04		imore,		
	mit. Partme cortan injur		21. Signature of Funeral Service Lice		Dayvi				iak Funer				
ŏ	Departing timbo		- Mas	1 della	un	13	30 E	Fort a	ve. Balti	more	Md. 2	230	
			23a. Part. Enter the disease, or con mock, or heart failure. List only	nplications that caused the one cause on each line.	e death. Do	not enter the m	ode of dying,	such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
E. F	hysician		immediate Cause (Final disease or condition resulting in death)	a Myoc	end	ral	Note	auct	700			Onset and Death	
	/Medical Examiner		Toodking in doubly	Due to (or as a d	consequence	of):							
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	consequence	of):							
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,00	e exe		resulting in death) Last	Due to (or as a d	consequence	of):							
0	cate b	dicai	•	d									
Y	ding ding	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy					2	3d. Date of deliv	erv	
200	death a atter d for u	ciar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tin		3 □Ectopic 5 □ Other (Month	Day Year	
5	by the	hys	9 Unknown	9∐ Unknown									
<u>ה</u>	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	þ	Part II. Other significant conditions	contributing to death but i	not resulting in	n the underlying	cause giver	in Part I.		obacco us Yes 2□		he cause of death	
ecords,	been should	Completed							-				
ž L	he law has ge 2 s	dm							24a. Was auto perfo		prior to co death?	opsy findings available of cause	of
NII A	in: Ti ificate or, pa	e Co	25. Was case referred to medical					26 Place of F	1 ☐ Yes Death (Check only of		1 🗌 Yes	2 No	
>	ysicie s cert direct	To B	examiner?	Hospital:	2 🗆 ER/Ou	utpatient 3 🗆 l	Other		Home 5 Resi		□Other (Speci	(v)	
5	ig Ph ter th		27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b.	Time of njury	28c. Injury a Work?		28d. Describe			<i></i>	
NSIO N	endin sath. or: Af he fur	atle	2 ☐ Accident investigation	on		M		es 2 No					
<u> </u>	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		- At home, fa (Specify)	ırm, street, facto	ory, office		28f. Location (City or To		Number or Run	al Route Number,	
_	To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier Certifying P	hysician: To the best of a miner: On the basis of ea	my knowledge	e, death occurre	nd at the time	, date and pla	ace, and due to the	cause(s) a	and manner as s	itated.	
	the I thin 2: the F mplets	Medical	one) 29b. Signature and title of certifies?	and manner state	d.		9c. License i				signed (Month,		
	8 4 8 4) In a	MD				2517			-1241		
	"XI		30. Name and address of person who	completed cause of dea	th (Item 23a)				Banto		213	2 ()	
	4		Covery Le			J. ROI	ling	RD /	Salto	MC	0 01	178	
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's	s Signature	A Della	£						

State of Maryland / Department of Health and Mental Hygiene 2004 05821 1 - For State Registrar Certificate of Death 2. Date of Death edent's Name (First, Middle, Last) **Physician** 4100 PM 241 2004 et /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6396 SHADOWSHAPE GOLUMBIA

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | HOWARD 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 K F 216.52.7417 Usual Residence of Decedent Yrs MD Director filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other treumatic event, the Wedical Examiner must be notified at 1 ☐ Yes 2 1 No Completed by Funeral Director COLLEMBIA HOWARD MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6396 SHADOWSHAPE 21045 PLACE USA or items 23s 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: BLACK Specify: 3 ☐ Widowed 4 M Divorced "netural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SOCIAL WORKER 12 TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked of any injury or other treumatic eve Pages 1 and 2 should be JAMES TAYLOR FLORFILLE COUNTS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6396 SHADOWSHAPE COLUMBIA STEPHANE BRYANI Date Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) GREENMOUNT BALTO. MO 21. Signature of Fugeral Service Lights e 22. Name and Address of Facility
VAUCHN C. GREEVE FUNDAL SERVICE 15151 BALTO. NATE PIKE, BALTO. MO 21229 23a. Part1. Entage he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dathy **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of) Box 68760. as the t IF FEMALE: esn. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ Division of Vital Records, Yes cate has been significant cate has been significant category. 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmed? certificate 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X esidence 6 □Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical npletely (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 31. Date filed (Month, Day, Year) 3. Registrar's Signature State FEB 2 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2000 2004 ELIZAB ETH 6-35AM BEHRINGER FEB /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Lutherville **Baltimore** Genesis-Brightwood If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 10, 1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖾 F 216-18-9649 81 Maryland Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural; or itema 23e or 28e-f show any Injury or other treumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Marvland Baltimore Idlewvlde 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1111 Arran Road 21239 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 ۵ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ years Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 8 Elizabeth Stewart Ehlers Kenneth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frederick R. Behringer, Jr. (son) 2627 SE 16th. Street Ocala, Florida 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 △Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Cardens 2-24-04 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 Ferran 23a. Parl1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical CONGESTIVE hOTERT KANUALE Montan Examiner Due to (or as a consequence of): Examine CAD 5, Q CAB (
Due to (or as a consequence of): physician and is the burial-trensit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYPERTENSION Records. P.O. Box 68760. ERRO Physician/Medical Due to (or as a consequence of): DENTIA Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 Yes 2 10 Division of Vitai or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hoepital or Attending Physic within 24 hours after death.
To the Funerel Director: After this c completely filled in by the funerel dir 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28c. Injury at Work? Dete of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1: Natural 1 □ Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier FEB 2090 2004 Spepta MD 00053150 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 515 BRIGTAGED RD CUTHERVICLEMOZIOGI COPTA ShowNAin 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 5 2004 Registrar

			1 - For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artmer rtifica:	nt of H	ealth a D <i>eath</i>	ınd M	ental Hyg	giene Reg. No.	200	۱4	05823
m	7	ar	1. Decedent's Name (First, Middle, La	ist)							2. Date of Dea Month	Day	Ye	ar	3. Time of Death
Çi.	Physici /Medic		Juanita			Bui					FEBRUA	RY	20,2		8:45 A
	Examin	er	4a. Feodity Name (If not institution, give	re street and nu	mber) Del Ce	nter.				OWS			County of D		imore
₩.	Funeral Director		,	Sex 1 □ M 2 💢 F	7. Age (<i>In yr</i> s. 71	last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day 12-14	h 7. Ye <i>ar)</i> 4–32	9.	Birthpla Countr Md.	ce (State or Foreign y)
	D .		Usual Residence of Decedent		140-0	. T								10	d Inside City Limits
	anylar show	١	10a. State 10b. County		10c. Ci	ty, Town or Lo								100	d. Inside City Limits Yas 2 No
	88-1	Director	Md NA			Baltin		p Code				10a Citi	zen of What	Countr	21
	with t		1 Cooperative Dr	civo Ar	nt 227		101. 21	212	2			rog. Citi	USA	Count	y:
	death with the Maryland ms 23a or 28e-f show fraust be notified at	Funeral	11. Marital Status		edent Ever in U	J.S. 13.	Was Dece			gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - A		
		듄	1 Never Married 2 Married	Armed Fi 1 ☑ Yes If Yes, Gi	orces?					, Puerto	Rican, etc.)		Black, V		
20	hours after tural, or ita	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G	ve Dates:	200	1 🗆 Yes	2.60 No	Specify:				Specify: [31ac	:K
9500-612	"natural",	etec	15. Decedent's E (Specify only highest gr			16a. Dece	kind of w	ork done o	durina most	of worki	ng	16b. Ki	nd of Busine	ess/Indu	istry
[2]	withir ane. than	Completed	Elementary/Secondary (0-12) 11th grade	College (1-4or 5+)	Labo	DO NOT	ise retired)			M	etal ("ı 1 + +	er
D	Hyg the	မ င	17. Father's Name (First, Middle, Last	1)		Парс			18. Mothe	r's Name	(First, Middle,				
<u>a</u>	0 20 D	To B	Lloyd		Pea	ays			Ada				Foste	2	
ary	id 2 should lith and Men 27 is marke treumatic	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Addres	s (Street a	and Numbe	r or Rura	l Route Numbe	r, City o	Town, Star	e, Zip C	Pode)
≥	and 2 ealth in 27 i		Floyd Buie	Husbar					e Dri						e, Md.2121
ore O	S T H		20a. Method of Disposition 1 Description 2 Cremation 3 Description 3 De	Removal from	State	Place of Dispo cemetery, crea	matory or	other plac			ate		cation - City		
galtimore,	Pages tment of tent: If it		* 4 Donation 5 ☐ Other (Speci	fy)	Ga	arrisor							ngs M:		
E D	permit. Page Department (importent: If any injury or snce.		21. Signature of Funeral Service Lice	w su	ne				s of Facility East		Ba. 1101 E		ore, N rth Av		21202
1			23a. Part1. Enter the disease, or com shock, or heart failure. List only	nplications that	caused the dea	th. Do not ent	ter the mo	de of dyin	g, such as	cardiac o	r respiratory ar	rest,			Approximate nterval Between
)	Physician		Immediate Cause (Final disease or condition	CON	GESTIV	E HEA	RT F	AIL	JRE						Onset and Death
	/Medical Examiner		resulting in death)	Due to GAS	(or as a consec TROINT	quence of): ESTIN	AL E	LEE	D						
	E CLASS	e	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consec	quence of):									
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. COL	ON CAN	ICER									
Š	be executed ician and burial-transit	Ex	resulting in death) Last	Due to	(or as a consec	quence of):									
à	ate hys	dicai	•	d										-	
٥ ×	death certific e attending p d for use as f	Physician/Med	IF FEMALE:	23c. If ves. ou	itcome of pregn	ancv							3d. Date of	deliven	,
X P P	atten atten i for u	clan	23b. Was decedent pregnant in the past 12 months?	1 🗆 Live	birth 2 Fet	aldeiath 3.[⊒Ectopic p ⊒ Other (s					1	Month		y Day Year
j.	the y th	hysi	1 L Yes 2 M No 9 □ Unknown	9□ Unkr	nown			-					_		
ທ໌ ກ	requires that een signed b nould be deta	by P	Part II. Other significant conditions	contributing to c	leath but not re	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco u	se contribut	e to the	cause of death?
9	w require been significant										1 D Y	'es 2[□No 3□] Probal	bly 4 Unknown
eco		Completed									24a. Was autop	sy	24b. Were prior	autops to com	sy findings available pletion of cause of
	sicien: The law certificate has l irector, page 2 s	S									perfor 1 ☐ Yes	2 No	deati		No.
Vital	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	8			OA Othi	0.0		(Check only o				
	Phy ratid	: To	1 ☐ Yes 25 No 27. Manner of Death	1.7	Inpatient 2 of Injury orth, Day Year)	28b. Time o		28c. Injun Worl	4 🗆 140		ne 5 Resid			specity)	
0	Attending I er death. ector: After by the funer	ig	1 Natural 5 Pending 2 Accident investigation		nth, Day Year)	Injury	м		k? Yes 2 □ l	No					
DIVISION	Attendi	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	200. Flat	e of Injury - At h	iome, farm, sti	reet, facto	ry, office		1	28f. Location (S City or Tow			r Rural i	Route Number,
5	pitel or Al	Cert	Tionno.		ang, etc. (opec	· <i>y</i> /									
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the t	e best of my kn pasis of examina nner stated.	owledge, deat ation and/or in	h occurre vestigatio	d at the time n, in my o	ne, date and pinion, deat	d place, a th occurre	and due to the ded at the time, d	cause(s) date and	and manne place, and	r as sta due to t	ted. he cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	0.0 1.1			25	c. License	e number		1	29d. Dat	e signed (M	onth, D	ay, Year)
	0		Salinge 1	111-01	o W.C)		D 41	410		F	chr	nong	20	1 2004.
	5		30. Name and address of person who												
					D. 764 Registrar's Sign	21 OSL	ER_	DRIV	E TO	WSOI	MARY	LAN	0 218	1214	
2	Sta Regista		31. Date filed (Worth Day, Year) PEB 2 5 200	34 50	MASSIAL SIGN	An	ales								

State of Maryland / Department of Health and Mental Hygien 2004 05824 For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Benton John 12:30 AM H. bruary 20 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimos e If Under 1 Year If Under 24 Hrs. Joseph 5. Social Security Number Ritclie Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5 77 - 2 7. Age (In yrs. last birthday) 6. Sex **Funeral** 10 M 2□ F Days Months Hours 68 217-30-4613 -7-35 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 FYes 2 □ No Baltimore MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA MOY 2110 212 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 110 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. important: if itam 27 is marked other than "na any injury or other traumatic event, the Medis once. Elementary/Secondary (0-12) College (1-4or 5+) Disable 3rd 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Henry Benton SR Croft Bar bara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. 152 N. Gueley St MEICE Patricia Kamsey 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2-25-64 GIEN Haver rem. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Softh Wesley Chariss of FH 2001 Eastern Ave 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto. MD. 2123 Immediate Cause (Final disease or condition resulting in death) METASTATIO Physician TRINMY BLADDER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical John H. Kenten IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) //CSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signat we are little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02/20/2004 > MO PHYSTEINN D 0055532 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAD (HAMES & 310, BATIMORE, MOULEY LIMM SITALABY, MO 6565 N. 31. Date filed (Month, Day, Year) FEB 2 5 32 Registrar's Signature State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05825 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 19 2007 KOWSKi Bes Nadzi 2004 Stephen /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimor Care furter If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 10 M 2 F 216-09-0843 Vrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel, or items 23a or 28a-f show any injury or other traumatic event, the Madical Exemither must be notified all once. 10a. State 10b. County 1 Yes 2 No MD Balt: more Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code PK. Ave 212 506 Son Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Dres 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Labor Mews paper 12+h 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Bernadzikowski USIN 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 210 42 19a. Informant's Name/Relationship (Type, Print) Beach Date 20 Pebble Frances
20a. Method of Disposition Macek 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Rosary -24-03 * 4 Donation 5 Other (Specify) Helv 22. Name and odress of Facility (N251e) Charis Sr. 2007 E 45 + 8CM Balto. complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inly one cause on each line. Enter the disease, or heart failure. Lat Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ARTENio Schenia CALDIO V He alex Physician resulting in death) /Medical Due to (or as a consequence of): Examiner DE 2 TENS ich Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (onas a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed DAG Mall, Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has culorii 1 Yes 2 No certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 47 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: All completely filled in by the fu death. investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 2 5 2004

ORIĞINAL

		1	For State Registrar		State of	Maryland /		ent of Health			giene 1eg. No. 2 (004	05826
	Physician /Medical Examiner		Decedent's Name OUSC a. Facility Name (II	2	ve street and numb	Car Hospin		ity, Town, or Location	on of Death	Date of Dea Month Coruga	Day	2004 Death	3. Time of Death
	Funeral Director		Social Security N	0187	Sex 7.	68	Yrs. Mont		der 24 Hrs. 8	Date of Birth	7935	S. Ca	ace (State or Foreign
	death with the Maryland rms 23a or 28a-f show rms 1 to invitio 1 at reral Director		MD State	10b. County		Ba/	Timore	2/				10	od. Inside City Limits 1 ☐ res 2 ☐ No
\	th with the Mar 23a or 28a-f sl		3934 U	Vestwe	ood Ave	*	101.	2/2/6			10g. Citizen of St.	What Count	ry?
15e	or, or its			ied 2 ☐ Married 4 ☐ Divorced	12. Was Decedon Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? PNo	If Yes,	scedent of Hispanic specify Cuban, Mexi s 2 No Spec	ican, Puerto Ri	fy Yes or No- can, etc.)		ce - America ck, White, e	
121215-C	ed within 72 ygiene. ner than "na it, I'm Medic		Elementary/Seco	h	rade completed) College (1-4		(Give kind of	Isual Occupation work done during in Tuse retired)				aceu	tical Co.
eifyland	B la b	1	William	n Len	non			Hn	nie	Wyni	Maiden Suman		
Mar.	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	,,	Tracy C	arter-	(Type, Print) - AUGh	ter c	2934	USTWO	ad Ave	Ba	110. m	0 21	216
$\mathcal{C}_{\mathcal{A}}$ Baltimore,	of of		`4 □Donation	Gremation 3 [4 00000	of Disposition (tery, crematory SON FO	rest VA	3-3-	04	Wing.	S Mil	IS, MD
Balt	permit. Pag Department Important: I any injury o once.		21. Signature of 5	4/1/1	fort		Gary F	and Address of Fa	FH 35	to Fred	hilton Pa	ss Ba	16, MD
٠	Pnysician /Medical		23a. Party Enter he shock, or he a shock, or he a shock or he a shock of the shock	(Final	nplications that cau y one cause on each a. Que to (or	sed the death. Death line.	a	node of dying, such	as cardiac or i	espiratory arr	rest,		Approximate Interval Between Onset and Death
K,092	ate be executed why social and why social and the burial-transit will all Examiner	1	Sequentially list co any, Jadang to mause. Enter Unde Cause (Disease or hat initiated events resulting in death) I	injury	c	as a consequence							
P.O. Box 68	The law requires that the death certificat are has been signed by the attending phypage 2 should be detached for use as the completed by Dhysic an Madilian		F FEMALE: 23b. Was deceden in the past 12 1 Yes 2[9 Unknown	months? □No	1 Live birt	me of pregnancy h 2 ☐ Fetal dea nt at time of death	ath 3 ⊟Ectopi	c pregnancy (specify)				ite of deliver	ry Day Year
	w requires that been signed be should be deta	ה ל מ	Part II. Other signif	ficant conditions	contributing to dea	th but not resulting	g in the underlyin	ng cause given in Pa	art I.		bacco use con		e cause of death?
Division of Vital Records,	: The law requirecate has been so page 2 should									24a. Was a autop: perfor 1 Yes	med?		osy findings available apletion of cause of
of Vita	hysician: Th this certificate al director, pag	2	25. Was case referexaminer?	100	Hospital: 1 Ving			DOA Other: 4		5 🗆 Resid	ence 6 Oth)
sion o	tal or Attending Phy rs after death. al Director: After this ed in by the funeral c		27. Manner of Deat 1 ☑ Natural 2 ☐ Accident	th 5 Pending investigate 6 Could not		Injury 28t Day Year)	o. Time of Injury M	28c. Injury at Work? 1 Tes 2		d. Describe h	ow injury occur	red	
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. I		3 ☐ Suicide 4 ☐ Homicide	determine	d 289. Place o	f Injury - At home, , etc. <i>(Specify)</i>				City or Tow	n, State)		Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	2	29a. Certifier (Check only one)	2 Medical Exa	hysician: To the b iminer: On the bas and manne	is of examination	dge, death occur and/or investiga	red at the time, date tion, in my opinion,	and place, an death occurred	d due to the c at the time, o	ause(s) and ma late and place,	anner as sta and due to	ited. the cause(s)
	with Com	2 2	29b. Signature and	title of certifier	ein.			29c. License numb	er -	2	29d. Date signe	d (Month, D	ay, Year)
		1	Shahr	ress of person who	completed cause	of death (Item 23	a) (Type Print)	Mani	land	Gerle	ral	HOST	oital
	State Registra		31. Date filed (Mon		32. Reg 2 5 2004	gistra Signature	M A	heule					

State of Maryland / Department of Health and Mental Hygiene 2004 05827 Certificate of Death 2. Date of Deeth Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year PEBRUARY **Physician** OLEMAN ,2004 1548 CHRISTINE /Medical 4b. City, Town, or Locetion of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Death Examiner HOSPICE BALTIMARE MERCY AT STELLA MARIS VIA. 7. Age (In yrs, lest birthday)
Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (Stete or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 7 F 708 12-34-Director IRGINIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Expansion must be notified at 1 XYes 2 □ No Be Completed by Funeral Director MARYLAND 10g. Citizen of Whet Country? 10e. Street end Number Herns 23a or DVIEW Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 A No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0020 Specify: Specify: 3 A Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) MRIVATE THGRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) Pages 1 and 2 should be I nent of Health end Mental I int: If item 27 is merked of SS/E -HARLIE 19b. Mailing Ad ress (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE: HD - 2/235
Date 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 Removal from State ö 4 ☐ Donation 5 ☐ Other (Specify) LANSDOWNE, MA Injury 22. Name and Address of Facility 21. Signature of Funeral Service Licensee . FULTON AVE Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical tastatuc of luces cancer **Examiner** Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical Examiner es the bunel-trensit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown eral Director: After this certificate has been signifiled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 L Y08 2 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPILE 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 27. Manner of Deeth 1 Naturaf Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Coufd not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours e 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D40854 20 2004 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) PLACE RISEBERG 301 ST. PAUL 32. Registrar's Signature 5 State Registrar

		Please 1 1 - For Registrar	State of Maryland	d / Department of F Certificate of	. Ensure All Health and Me Death	ental Hygiene Reg. No	e 2004	05828
Physi /Med	cian dical	1. Decedent's Name (First, Middle, Last)	COOK		F	Month Da BRUARY	20 Year	3. Time of Death
Exam	iner	4a. Fecility Name (If not institution, give :	Hospital Ca		ALLSTOWN		3 ALTIN	
Funera Directo		5. Social Security Number 6. Set 133-30-3991	7. Age (In yrs. I	Asst birthday) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Year) June 12,		hplace (State or Foreign ountry) otland
e Maryland	ctor	10a. State 10b. County MD Baltimon		, Town or Location Baltimore				10d. Inside City Limits
with th	Dire	10e. Street and Number 4204 Old Milford	Mill Road	10f. Zip Code	21208	10g. C	itizen of What Co USA	ountry?
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heatth and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at	by Funeral Director		12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:	S. 13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Rece - Ame Black, Whit Specify: Wh	e, etc.
ed within 72 hours af rgiene. For than "natural", or t, the Wedleal Exam	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working d)	16b. ł	Cind of Business	Industry
it Hygier other th	e Cor	17. Father's Name (First, Middle, Last)	U	salesperso	n 18. Mother's Name (First, Middle, Maidei	_electro n Sumame)	nics
Menta Menta Mrked arked	To Be	Howard William Jan	es Cook		Verona Ba	in		
and 2 should be file ealth and Mental Hy n 27 le marked oth er traumatic event		19a. Informant's Name/Relationship (Ty Joan Cook/spouse		19b. Mailing Address (Street 707 Sudb	rook Road 1	Baltimore.		
permit. Pages 1 ar Department of Hea Important: If Item	Ì	20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other Specify)	lemoval from State	lace of Disposition (Name of emetery, crematory or other pla	Ce) Dat	de 20c. L	ocation - City or	Town, State
permit. Depart Import	SDCS	21. Signature of Euneral Service Licens Rona Let S	lade, Director	State Anat baltimore,	omy Board	655 W. Ba	ltimore	Street
Physicia /Medica Examine	al	23a. Part . Enter the diseas for complished or heart failure. List only or immediate Cause (Final disease or condition resulting in death)		A1 400	ng, such as cardiac or r	respiratory arrest,		Approximate Interval Between Onset and Death
E.E	Examiner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):				
ate be executed hysicien and the burial-transit	100	resulting in death) Last	Due to (or as a consequ	uence of):				
that the death certificate be executed that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 Ectopic pregnance	у		23d. Date of del Month	ivery Day Year
law requires that the as been signed by the 2 should be detached	þ	Part II. Other significant conditions con		ulting in the underlying cause gi	ven in Part I.		use contribute to	the cause of death?
The ste h	Completed					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
Physician: The this certificate hiral director, page	o Be	25. Was case referred to medical examiner?	lospital: 1 npatient 2	ER/Outpatient 3 DOA	26. Place of Death (Check only one) 5 🗀 Residence	2 Flore - /2-	
Attending Physic death. ector: After this by the funeral did	I	27. Napner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury Wo		d. Describe how inju		cny)
al or Attending after death. I Director: Afte d in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, office	28	f. Location (Street a City or Town, Stat	nd Number or Ru e)	ıral Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical C	29a. Certifier Control Phy (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurred at the ti tion and/or investigation, in my o	me, date and place, an opinion, death occurred	d due to the cause(s at the time, date an	s) and manner as id place, and due	stated. to the cause(s)
To the within To the comp	W	29b. Signature and utile of certifier		29c. Licens D48	se number 123	FEB	ate signed (Monti RUARY	20 AOO
		30. Name and address of person who co	LI HARIS	5H 541	THWEST I	TOSPITAL OURT R	M CAO	TER 10 21133.
Regi	State strår	31. Date filed (Month, Day, Year) FEB 2 5 20	32. registrar's Signa	ture Appelle				

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			1 - State Registrar				Ce	rtificate o	f Death			Reg. No.			
	Physici	an	Decedent's Name (First, M.							2	2. Date of De Month 02	Day	Year	j	e of Death
	/Medic		Ferne G. Co								02	2(40 P ^M
)	Examin	er	4a. Facility Name (If not instit					4b. City, Town			1		County of Deel		
	7		Catonsville 5. Social Security Number	6. Sex		a (la urs	last birthday)	If Under 1 Year					Baltim		to or Foreign
La [®]	Funeral Director		487-22-8275 Usual Residence of Deceder	1		33	Yrs.	Months Day		Min.	Date of Bir (Month, De Feb. 2	y Yeer)	921 Te	xas	ate or Foreign
	and w		10a. State 10b. Co			10c. Cit	y, Town or Lo	cation						10d. Insid	e City Limits
	Mary	ō	MD Hov	vard		Col	umbia	ı						10	Yes XIXNo
	n 72 hours after death with the Maryland "naturelt, or items 23s or 2se-f show edical Examiner must be notified at	Funeral Director	10e. Street and Number 5570 Vantag	je Po	int Road	d#5		10f. Zip Code 210				10g. Citi	zen of What Co	ountry?	
	death	era	11. Marital Status		12. Was Decedent I	Ever in U	.S. 13.	Was Decedent of If Yes, specify C	f Hispanic Or	igin? (Speci	fy Yes or No	-	14. Race - Ame		n,
	or its		1 Never Married 2	Married	Armed Forces? 1 ☐ Yes 2 🔀	40		_			can, etc.)		Black, Whit		
o-0030	72 hours after natural', or ite iteal Examine	i by	3 Widowed 4 □ Divo	rced	If Yes, Give Year or Dates:			1.∏Yes 2 X N	to Specify:				Specify: B	lack	
ה ה	72 h	Completed	15. Dec	edent's Edu	cation e completed)		16a. Dece (Give	dent's Usual Occ kind of work dor DO NOT use ret	cupation ne during mos	st of working	,	16b. Ki	nd of Business	Industry	
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Ž	s 1 and 2 shou f Health and M item 27 is mar other traumati	Į.	19a. Informant's Name/Rela Doris Richa			r	5400	ng Address (Stre) Vanta	ige Po	oint 1	Road	Apt 8	814, Co	lumb	1045 1a, Ma.
Бапитоге,	permit. Pages 1 a Department of He Important: If item any injury or oth ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crema: 4 ☐ Donation 5 ☐ Othe			C	emetery, cre	osition (Name of matory or other p on Nat	olace)	Dai			cation - City or rlingt		
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			show, what failure.	List only or	ne cause on each lir	10.	-	F .						Onset a	Between and Death
ş	Physician /Medical		disease or condition resulting in death)		Due to (or is	e consen	uence on	Fanl	mi						
	Examiner				Cha	200	0	antino	Car	Pul	mume	5.00	Dunce	~	
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	Due to (or as	a conseq	uariou of):	2 7 7 7 7 ()	COVIC		7777	-			
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	1	. De	me	te								
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200	tificat g ph) as th	ed										- 1-			
X Q Q	death certificate be execul e attending physician and od for use as the buriat-tra	Physician/Medic	IF FEMALE: 23b. Was decedent pregnan	it i	3c. If yes, outcome 1 ☐ Live birth			JEctopic pregnar	ncv			2	23d. Date of del	-	
מ	0 0	SICI	in the past 12 months? 1 ☐ Yes 2 No		4☐Pregnant at			Other (specify)					Month	Day	Year
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		Соп										rmed? 2☐No	death?	2 🗆 No	
VITAI H	ysician: Th is certificate director, pag	Be (25. Was case referred to me examiner?							e of Death (Check only o	ne)			
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_ _	ding P h. After t funera	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pe	ending	28a. Date of Inju (Month, Day	ry y Yeer)	28b. Time o Injury	V			d. Describe I	now injury	y occurred		
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DIVISION	or Attending Physician: after death. Director: After this certific in by the funeral director.	Certification:		termined	28e. Place of Injubulding, etc			reet, factory, offic	е	28	f. Location (S City or Tox		d Number or Ru)	ıral Route l	Vumber,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	(Check only 2 Med	tifying Physical Exami	sician: To the best of	of my kno examina	wledge, deat	h occurred at the	time, date ar	nd place, an	d due to the	cause(s)	and manner as	stated.	se(s)
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	7 Will		29b. Signature and title of ce	Tullel O	Ildan 1		M)		3(4	16			23/C		.,
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	V		30. Name and address of pe	rson who co	ompleted cause of d	eath (Iten	n 23a) (Type,	Print)	0	CL	6. 1	. 7	08 130	ich r	n1) 2123
			31 Date filed (Month Day)	(ear)	32. Redistra	7	8-21	10 2	nous	21	un	u -	0		1021-
	Sta Registi		31. Date filed (Month, Day, 1	252	004	Man Signa	St.	bull							

		•	1 - For State of N Registrar	Maryland /	Department of H Certificate of	lealth and Me Death	ntal Hygien	e 2004	05830
	Physici		1. Decedent's Name (First, Middle, Last) Robert Mason Clark					22, 2004	3. Time of Death 5:35P
F	/Medic Examin		4a. Facility Name (If not institution, give street and number	nr)	4b. City, Town, or	Location of Death		Ic. County of Death	1_3:35P
			Maplewood Park Place		Bethesd			Montgomery	У
	Funeral		4√TM 2□ E	Age (In yrs. last b	yrs. If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea an. 13,	9. Birthp	lace (State or Foreign try)
	Director	-	709-18-7416 Usual Residence of Decedent	92	113.	J	an. 13,	1912 Kans	sas
	yland		10a. State 10b. County	10c. City, Tox	wn or Location			11	0d. Inside City Limits
	e Mar	ctor	Maryland Montgomery	Beth	nesda				1 ☐ Yes 2X No
	with th	Directo	10e. Street and Number		10f. Zip Code			Citizen of What Coun	
	eath v	eral	9707 Old Georgetown Road 11. Marital Status 12. Was Deceder	nt Ever in II S	20814	ispanic Origin? (Specif		nited Stat	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f ahow aumatic event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced 1 Year or Dates	s? ŌNo	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	an, etc.)	Black, White, o	etc.
9	2 hou		15. Decedent's Education		a. Decedent's Usual Occup	ation	16b.	Whi Kind of Business/Inc	
215	thin 7:	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4c)	or 5+)	(Give kind of work done of life. DO NOT use retired	during most of working f)			
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pue	~ a	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (F		en Sumame)	
Ž	es 1 and 2 should be of Health and Menti of Health and Menti fitem 27 is marked r other traumatic e	ဥ	Charles Courtney Clark 19a. Informant's Name/Relationship (Type, Print)	19	9b. Mailing Address (Street)	Lena Ho		or Town State Zin	Code)
∑	and 2 sealth an n 27 la		Nancy C. Culp/Daughter		8201 Postoak)854
5	s 1 au of Hea item othe		20a. Method of Disposition		of Disposition (Name of ery, crematory or other place	Date	20c.	Location - City or To	
Ē	Peges nent of int: If it ary or o		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	18 Montg	comery torium Inc	24, 20	004 Be	thesda, M	aryland
Baltimore, Maryland 21215-0036	permit. Peges: Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licensee	M00803	Bethesda-C Bethesda,	ss of Facility Robe hevy Chase Maryland	rt A. Pur 1nc 20814-35(nphrey Fur 7557 Wisco	neral Home/ onsin Avenue
8760,	Physician /Medical Examiner e attending physicien and tor use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	line.	eart Failure e of): e of):				Interval Between Onset and Death
P.O. Box 68	the death certifical by the attending phy ached for use as th	Physiclan/Med		2 Fetal deat at time of death	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	ry Day Year
rds, P	The law requires that the dei tie has been signed by the a bage 2 should be detached f	by	Part II. Dther significant conditions contributing to death Strokes	but not resulting	in the underlying cause give	en in Part I.	23e. Did tobacco	o use contribute to th 2 XNo 3 ☐ Prob	e cause of death? ably 4 □Unknown
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Vita	itcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:		Other and DOA Other	26. Place of Death (C			Assisted
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Divis	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined 28e. Place of building,	Injury - At home, i etc. (Specify)	farm, street, factory, office	28f	Location (Street a City or Town, Sta	and Number or Rural ite)	Route Number,
	the Hospi in 24 hou. the Funer ipletely fill	edical	29a. Certifier (Check only one) 1X Certifying Physician: To the be 2 Medical Examiner: On the basis and manner	of examination a	and/or investigation, in my o	pinion, death occurred	at the time, date a	nd place, and due to	the cause(s)
	To To Con	Σ	29b. Signature and title of certifier		29c. Licenso	e nu <i>m</i> ber	29d. D	Date signed (Month, L	Day, Year)
	0		· Offee	21/	D26	259	Feb	ruary 23,	2004
	. 8		30. Name and address of person who completed cause of Ava A. Kaufman, M.D. 82.		nsin Avenue,	#103 Bo+1	oode M-	nular 1 o	091/
	Sta	ite	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature		"TOD, DELI	icoua, Ma	rryrand Z	0014
	Registi		FFB 2 5 2004	M	Armall 1			1	

			For		State of N	larylan	d / Dep	artment of h	lealth and	Mental Hy	giene 200	4 05831
			1 - State Registrar				Ce	ertificate of	Death	F	Reg. No.	
	Physicia	an	Decedent's Name (F							2. Date of Dea Month	Day Year	3. Time of Death
1	/Medic	al	Norman	Lee	Curry	e)		4h Cihi Tourn a	r Location of Dea	Februar	4c. County of De	
	Examin	er	4a. Facility Name (If no				10			1411		atri
340	Funeral	*	Upper Che 5. Social Security Numb			Age (In yrs. I			If Under 24 Hr	s. 8. Date of Birtl	Harford 9. Bi	rthplace (State or Foreign
	Director		258-36-64	74	Ø M 2□F	73	Yrs.	Months Days	Hours Mir	Jan. 2	4, 1931 Ge	orgia
2			Usual Residence of De 10a. State 10	cedent b. County		10c Cib	, Town or L	ocation				10d. Inside City Limits
April 6	e da la la	5		,				Countri				1 Yes 2 No
the A	286-	ect	Maryland H			Bel	Alr_	10f. Zip Code			10g. Citizen of What C	Country?
dia.	Hygiene. Hygiene than "natural", or Items 23a or 28e-f show ent, Ita Medical Evaruinet must be routified at	Funeral Director	5 Inverne					21014			USA	,
the of	ms 2	nera	11. Marital Status		12. Was Deceder Armed Forces	t Ever in U.	S. 13	. Was Decedent of H If Yes, specify Cub-	lispanic Origin? (Specify Yes or No-		
و و	or Ite	F	1 Never Married		1 X Yes 2]No		1 ☐ Yes 2 No	Specify:	nto rican, etc.)	Black, Wh	ite, etc.
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<u>ה</u> ב	patrice	Completed	(Specify (. Decedent's Econly highest gra	de completed)		16a. Deci (Giv	edent's Usual Occup e <i>kind of work don</i> e DO NOT use <i>retire</i>	ation during most of w	orking	16b. Kind of Busines:	s/Industry
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	othe othe	BeC	17. Father's Name (Firs	st, Middle, Last,	Sa Control				-		Maiden Sumame)	
= 2	Mental Marked o	To B	Pembroke	Rol	and (Curry			Norma	Mary 1	Elizabeth	Kershaw
aryle	and is m	·	19a. Informant's Name					_			or, City or Town, State,	
≥ °	Health em 27 ther tr		Jerry L.	_	Wife	1005 0	Address of the Particular		ay, Bel		yland 2101	
	or othe		20a. Method of Disposi 1 ☐ Burial 2 ☑C		Removal from Stat	e C6	emetery, cre	osition (Name of ematory or other place		Date	20c. Location - City o	r Town, State
	rtmen rtant: njury		4 □ Dorlation 2	other (Specification)		Hil		Serv. Cor			Towson, Mar	
ם ם	Department of Pingortant: If Ite any Injury or of once.			II Hervice Zicer	_ +						uneral Hom	e, P.A. yland 21050
lý.			23a Fart1. Enter the c	lisease, or com	plications that caus	ed the death		nter the mode of dyir				Approximate
D	hysician		Immediate Cause (Fina		one cause on each	ine.	11.	Ano	=10 C	SEP	515	Interval Between
	/Medical		disease or condition resulting in death)	-	a. Due to (or a	is a consequ	ience of):	The	ena	861	0, -	8 0.1/2
Ε	xaminer		Sacuentially list condit	ions	b							
3	7 7	Examiner	S - uentially list conditi if any, leading to imme- cause. Enter Underlyin Cause (Disease or inju-	diate	Due to (or a	is a consequ	ience of):					
ou,	and I-tran	хаш	that initiated events resulting in death) Last		c. Due to (or a	is a consequ	ience of):					
007	attending physicien and for use as the burial-transit	calE					0.100 0.7.					
Y OO X	g phy:	_			_ d							
X S	esn	M/M	IF FEMALE: 23b. Was decedent pre		23c. If yes, outcom			∩Estable processes			23d. Date of de	alivery
ם ליפול	0 0	sicia	in the past 12 moi 1 🗆 Yes 2 🗆 No		4☐Pregnant 9☐Unknown			□Ectopic pregnancy □ Other (specify) _			Month	Day Year
ב ב	ed by the a	Physician/Med	9 Unknown					555755577				
The factorities from the	s been signed be should be delt	by	Part II. Other significan	PHE	ontributing to death	VA-	Itting in the	underlying cause giv		23e. Did to	obacco use contribute	to the cause of death? Probably 4 Unknown
cords	pinod	Completed	Dun (2	F MAR	01	1574	1110 8				
ည်း ရ	hast 3e 2 s	mpf	Ovn-o	2/0	S THE	-	2			24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
		e Co	25. Was case rearred	ERL	1/11015	mil	4			1 Tes	2 No 1 Ye	s 2 No
OI VIII	r this certifica	o Be	examiner?	10 madical	Hospital:	tient 2 🗆	ER/Outpatie	ent 3 DOA Oth	Ar.	Bath (Check only or	ne) lence 6 □Other (Spi	neit i
5	er this	Hü	27. Manner of Death		28a. Date of In (Month, D		28b. Time		y at	-	low injury occurred	эспу)
VISION	death. ctor: After y the funer	atlo	2 Accident	Pending investigation	1	ay rear/	Injury		Yes 2 □ No			
Ž	irecto	Certification:	3 Suicide 6	Could not b determined	286. Place of I	njury - At ho etc. (Specify	me, farm, s	treet, factory, office		28f. Location (S City or Tow	Street and Number or F m, State)	fural Route Number,
noising of bigging	urs af vel D											
2	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Ph Medical Exar	niner: On the basis and manner:	of examinat	wledge, dea ion and/or i	ith occurred at the tir nvestigation, in my o	ne, date and place pinion, death occ	ce, and due to the d curred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
4	o the	Mec	29 . Signature and title	of certify	and manner	7		29c. Licens	e number	- 2	29d Date signed (Mon	th, Day, Year)
۲	(i	+ XAm	V42	hand	1	5	7	31775	1	EBRUAL	4 20,2004
	1XU		30. Non and address	of person who	completed cause of	deathyltein	(Type	300 A1	Kor	3		21049
	10		JEAN P	. EDW	ANDS	OVI	G	fustor	J, M	ARYL	ENF C	41071
	Sta		31. Date filed (Month, I		32. Regis	strar's Signat	ture		(-	
	Registr	4.1	FFR 9	5 2004								

2/00/04

	1 - For State Registrar	State of Maryland	/ Departr	nent of H cate of L	eaith and Death		Reg. No.	004	0583
Physician /Medical	1. Decedent's Name (First, Middle, Last) DOROTHY L.	DAVAGE				2. Date of Dea Month 2/1	9/04	Year	3. Time of Death 6:25 PM
Examiner	4a. Facility Name (If not institution, give si MARINER HEALTH	H (OVERLEA)		BALT	Location of Dea			ty of Deeth	
Funeral Director	220 00 2001	7. Age (In yrs. las		Under 1 Year onths Days	If Under 24 Hr Hours Min		Year)	9. Birthp	MD .
death with the Maryland ms 23e or 28e-f show rinust be notified at nerral Director	Usual Residence of Decedent 10a. State 10b. County MD . n/a	10c. City,	Town or Location	MORE			10a. Citizen o		0d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with the 23a or 2	11 WEST 20th	STREET (APT	17L)		1218		Ţ	JSA	
336 urs after death v al; or items 236 regretter count by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 27 No If Yes, Give Year or Dates:	If Yes	Decedent of Hi s, specify Cuba Yes 21 No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		ace - Americ ack, White, afy: B	
5-00 72 ho	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation		s Usual Occupa of work done of NOT use retired	during most of w	orking	16b. Kind of	Business/In	
Maryland 2121: 12 should be filed within hand Mental Hygiene. 7 is marked other than "ricementic event, the Mental Hygiene. To Be Comple	17. Father's Name (First, Middle, Last)	GGETTS				ame (First, Middle,	Maiden Suma	ime)	
Mary and 2 shou all and M 127 is mar er traumat	19a. Informant's Name/Relationship (Type CHARLES V. KINC	G SON	3414	FAIRV		Rural Route Numbe	O. MD.	212	16
Pages 1 ament of the ent: If them ury or oth	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Ro 1 ☐ Donation 5 ☐ Other (Specify)	amoval from State	ce of Disposition metery, cremato	ry`or other plac	ORY 2/2	Date 21/04	CATON	,	LE, MD.
Balt permit. Depart Import any inj	21. Signature of Funeral Service License	Staff	22. Na F	STEP	BROS". DTAW P	FUNERAL L. BALTO	O. MD.	P ₂ A ₂	17
bhysician and he be executed Examiner the burial-transit dical Examiner	Immediate Cause (Final disease or condition resulting in death) a figure 1 tally 1st conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	N (JK)	14 RY	K JANDE	7.		6 mo
Box 6	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ₩6 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 □Ect	opic pregnancy ner (specify)				Date of deliver	ery Day Year
rds, P.O. quires that the nasigned by the detache	Part II. Other significant conditions con		ting in the under	lying cause give	en in Part I.	23e. Did t	_/		he cause of death? pably 4 Unknown
Division of Vital Records, to attending Physician: The law requires to alter death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by						24a. Was autor perio 1 Yes		o. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of
f Vital F ysiclen: Thy ysiclen: The director, page To Be Col	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3□ DOA Oth	or /	eath (Check only of		ther (Special	5/I
Vision of Vital Attending Physicien: Gleath. sctor: After this certifica by the funeral director, to	27. Manne Death 1 Astural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injun Wor		28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division c tel or Attending P rs after death. el Director: After t ed in by the tunera Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street,	factory, office		28f. Location (. City or To:		mber or Rura	al Route Number,
Hospi 4 hou Funer ely fill	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my know her: On the basis of examinati and manner stated.	rledge, death oc on and/or invest	igation, in my o	pinion, death oc	ce, and due to the curred at the time,	date and place	e, and due to	o the cause(s)
To the within 2 To the complet	29b. Signature and title of certifier			29c. Licens			29d. Date sign	ned (Month,	-
-11		41			7945				7004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** February 21, 9:35pm Louise 2004 /Medical Dietz 4a Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Country Meadows If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Mar 27, 19 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 90 201-26-1956 1913 Director Pennsylvania Usuel Residence of Decedent filed within 72 hours efter death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at Maryland Frederick Frederick 1 ☐ Yes 2X No **Funeral Director** 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 5955 Quinn Orchard Road 21704 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify: White Completed by 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be filed within Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. the Man College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) B Walter George Kanach Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Dr. Albert G. Dietz, Jr/Son 7503 Melbourne Place, Ijamsville, Maryland 21754 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t Burial 2 □ Cremation 3 □ Removal from State St Mary's Polish Cemetery Mar 4,2004 White Oak, Penn 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home

106 Fast Church St, Frederick, Maryland 21701

Reprit Enter thy disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical a Acute Gastrointestinal Bleed 7 days Examiner Due to (or as a consequence of): Physician/Medical Examiner Hypertension Years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Coronary Artery Disease Years that initiated events resulting in death) Last Due to (or as e consequence of) Diverticulosis Years Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2√No 3 Probably 4 Unknown Osteoporosis; Anorexia; Failure to thrive; Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Anemia; Depression; Anxiety 1 Tes 1 ☐ Yes 2 ☐ No 2KNO Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Other: 4☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter deeth.

To the Funeral Director: A completely filled in by the fu

Registrar

State

edical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Allen Reilly, M.D.,

801 Toly House Avenue, D-1, Frederick, Maryland 21701-6111

29d. Date signed (Month, Dey, Year)

February 22, 2004

2º15 2004

32. Registrar's Signature Esca

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted.

29c. License number

D54749

DHMH 17 Rev 1/2001

State

Registrar

Year)

5 2004

2

State of Maryland / Department of Health and Mental Hygiene 2001

				Certifica	ate of Death	Re	g. No. ZUU4	05835
	Discostation.	1. Decedent's Neme (First, Middle, L	ast)			2. Dete of Deeth Month	Day Year	3. Time of Death
Le.	Physician /Medical		iGiacomo			Feb. 23		10:30am
and the	Examiner	4e Fecility Neme (If not institution, g				or Location of Deeth	4c. County of Death	
	10	Millennium Nur				ott City	Howard	
	Funeral Director	5. Social Securify Number 6. 228–42–3048	Sex 7. Age (In yr. 1	s. last birthday) If Un Yrs. Month	der 1 Year If Under 24 H		9. Birthy <i>Coul</i> 1933 Md.	
	2 2	Usuel Residence of Decedent 10a. Stete 10b. County	100 (City, Town or Location				
	anyla sho		100. 0	Ellicott	City			10d. Inside City Limits 1 ☐ Yes 2 No
	Sea-f	10 Control No.						
	urs after death with the Mar ai', or items 23a or 28a-f si Saminer must be notified by Funeral Director	10e. Street end Number 12194 Mount Al	bert Rd.	10f.	Zip Code 21042	10	g. Citizen of Whet Coul USA	itry?
_	tar des items Inerm	11. Maritel Status 1 ☐ Never Married 2 X Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 24 No	U,S. 13. Was De If Yes, s	cedent of Hispenic Origin? pecify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White,	
020	rai', or	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2⊠ No Specify:		Specify: Whit	:e
15-0	led within 72 hou ygiena. For then "natura it, the Medical E. Completed	15. Decedent's (Specify only highest g		16a. Decedent's U (Give kind of	sual Occupation work done during most of w Tuse retired)	orking 1	6b. Kind of Business/In	dustry
212	d with giena. or than	Elementary/Secondary (0-12) 12 yrs.	College (1-4or 5+)	Cle			Retail	
Maryland 21215-0020	Mantal Hy Mantal Hy srked othe stic event	17. Fether's Neme (First, Middle, Las				ame (First, Middle, M	aiden Sumame)	
Mary	nd 2 showaith and N 27 is main ir trauma	19a. Informant's Name/Relationship	(Type, Print) acomo husban		ess (Street and Number or I			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marital Hyglena. Department of Health and Marital Hyglena. Introortant: If item 27 is marked other than "natural", or items 23s or 23s-f show important: If item 27 is marked other than "hattural", or items 23s or 23s-f show any injury or other traumatic event, the Medical Examiner must be notified at ance. To Be Completed by Funeral Director	20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Themoval from State	Place of Disposition (for cometery, crematory of Cownsville	lame of rother place) V.A. Cem.	Feb. 26	Oc. Location - City or To	
Balti	pemit. Departmimportai	21 Signature of Funeral Service Lice	ensee	22. Name Conne	and Address of Facility IIV Funeral I Sollers Point	Tome Of Du	ndalk	
		230 Part Street the disease of an						
		23a. Pert / Emer the disease, or conshook, or heart failure. List only			lode of dying, such as cardi	ac or respiratory arres	St,	Approximate Interval Between Onset and Death
1	Physician /Medical	Immediate Cause (Final	Pick	2	ISEASE		1	Onset and Death
	Examiner	disease or condition resulting in death)	a		307,30			
	je de la composition della com		Due to	(or as a consequence of	rf):			
M	ficate be executed physician and is the burial-transit edical Examiner	S	b.	(or as a consequence o	0		10	
, 0	an an rial-tr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	00010	(or as a consequence o	,,,-			
68760,	te be ysicie re bu	Cause (Disease or injury that initiated events	c. Due to (or as a consequence o	n:			
89 X	_ 0 0		d					
8	attend of for us	Part II Other elemitionat conditions			B-11	Och Bidark		
J.	as that the death cer igned by the attendin be datached for use by Physician/N	Part II. Other significant conditions	contributing to death but not re	saking in the andenying	g cause given in Part I.		acco use contribute to 3 □ Prol	
Ś	as the igned be de							
Records,	The law requiras that the death also been signed by the atter page 2 should be datached for a Completed by Physicial					24a. Was en performe	ed? ava	ere eutopsy findings ailable prior to mpletion of cause death?
2	Tha lav te has bage 2					1 ☐ Yes		Yes 2 No
<u>=</u>	slan: 'sartifica artifica actor. p	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one,		
_	hysic his ca Il dire To I	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient 3☐	OOA Other: 4 Nursing	Home 5 ☐ Residen	ce 6 □Other (Specif)	()
0 0	th. After the function of the	27. Menner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
DIVISION OF VITAL	To the Hospital or Attending Physician: Tha law within 24 hours aftar death. To the Funeral Director: After this cartificate has be completally filled in by tha funeral director, page 2 s Medical Certification: To Be Comple	3 ☐ Suicide 6 ☐ Could not determined	28e. Plece of Injury - At I building, etc. (Spec	home, farm, street, factorify)	ory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
	Ne Hospita n 24 hours ne Funera pletaty fille edical (29a. Certifier 1 Certifying P (Check only one) 2 Medicat Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, deeth occurre ation end/or investigation	d et the time, date and placen, in my opinion, death occ	ce, and due to the cau curred at the time, date	se(s) and manner as st e and place, end due to	ated. the cause(s)
	withir To th comp	29b. Signature and title of certifier		2	9c. License number		I. Date signed (Month,	Dey, Yeer)
	Ω	Vasirem	Valle	mi	1)2819.		401204	<i>)</i>
	7	30 Name and eddress of person who	completed cause of death (Ite	m 23a) (Type, Print) 220 /	PARK HE	1 Gots 1	AVE BAC	10 MI)
3	State	31. Dete filed (North Day Year)	12 Registrar's Sign	divine America	•		21	201
	Registrar	D)		15				

State of Maryland / Department of Health and Mental Hygiene 2004 05836 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 23, 2004 **Physician** 03:23 P M William Dobbs Mayo /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S CAMP SPRINGS MALCOLM GROW MEDICAL CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 🕅 🎢 2□ F Director 228-22-1877 Usual Residence of Decedent V A Jan. 27,1926 death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County rthan "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at Prince 1 ☐ Yes 2√2 No Funeral Director Maryland George's Upper Marlboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20772 U.S.A. 9204 Columbine Lane 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nent if item 27 is marked other than "natural; or [te ary or other traumatic event, the Marcinal Exemina 1 Ves 2 No 1943 - If Yes, Give Year or Dates: 1963 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 1963 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Capitol Elementary/Secondary (0-12) College (1-4or 5+) Police 12th Officer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Allen Dobbs Cleva ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 310,000) 19a. Informant's Name/Relationship (Type, Print) 9204 Columbine Lane Upper Marlboro, Elizabeth Dobbs (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages I Department of H Importent: If ite any injury or ot once. March 3, N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets. Cem. Cheltenham, 2004 21. Signature of Funeral Service Leense 22. Name and Address of Facility Lee Funeral Home, Inc. 90 6633 Old Alexandria Ferry RD Clinton, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrestMd 20735 shock, or heart failure. List only one cause on each line. Immediate Cause (Final NON-SMALL CELL LUNG CANCER YEARS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Ecquentially list our cations, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-tran and Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2√ TyNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2√2 No ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. Il Director: After Certification: 5 Pending Injury 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1A 025554 30. Nam and address of person who completed cause of death (x m 23a) (Type, Print) 89 MDG / 1050 W. PERIMETER RD. ANDREWS AIR FORCE BASE, MD 20762-6600 FLETCHER, CAPT, USAF, MD 32. Registrar's Signature. 5 Registrar

			For State Registrar	State of Maryla	and / Depa	artment of F	lealth and		giene 20	04 0583
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last	Dixo	n	4b. City, Town, o	r Location of De	2. Date of De Month + PDTUs	Day Y	3. Time of Death
	Funeral Director		212 30 7207		rs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Bir	N/A th Year) 1931 N	3. Birthplace (State or Foreign Country) Maryland
	72 hours after death with the Maryland netural; or iteme 23e or 28e-f show digal Examirer mast be routified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		city, Town or Lo Baltimor	е			10a Cibiraa at Mh	10d. Inside City Limits TYPY Yes 2 No
	e 23e or 2	Funeral Director	2534 Druid Hill A		-115 423	10f. Zip Code 21217	liana dia Osinia 2	/Sanata Van an Na	USA	
9800	ours after death with the Marylan rai', or iteme 23a or 28a-f show Examiner must be notified at	Ď	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1. 100, 0	1050	was Decedent of F f Yes, specify Cubi I ☐ Yes 2 No	an, Mexican, Pui	(Specify Yes or No erto Rican, etc.)		· American Indian, White, etc. Black
21215-0036	yiene.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired S Examin	during most of w d)	vorking	Social S Administ	Security
Maryland	d 2 should be filed th and Mental Hygi 7 Is marked other traumatic event, it	To Be C	17. Father's Name (First, Middle, Last) William Henry Dix 19a. Informant's Name/Relationship (19h Mailin	in Address /Street	Mary 1	Ida Carr	. Maiden Sumame) er, City or Town, St	
	s 1 and 2 sho of Health and item 27 le m other traum		Maria Dixon/Daugh 20a. Method of Disposition	ter		Druid H			1timore,	MD 21217
Baltimore,	permit. Pages Department of I mportant: If the any Injury or of once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specification)	Removal from State	detro Cr	ematory or other place	Inc. 2-2	24-04	Baltimor	
Bal	Depar Impor eny In		21. Signature of Funeral Service Life Fdward A G	regorchik	²² 2	. Name and Addre remation 99 Fredet	Society rick Roa	y of MD, ad Balt	Inc. imore, MI	21228
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ords, P	The law requires that the tite has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions of	ontributing to death but not	resulting in the ur	nderlying cause giv	ven in Part I.			ute to the cause of death?
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Division	i Di it o	Certification;	3 Suicide 6 Could not b	building, etc. (Sp.	ecify)			City or To	wn, State)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 2 Medical Example one)	ysicien: To the best of my niner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	n occurred at the til vestigation, in my o	me, date and pla opinion, death oc	ice, and due to the curred at the time,	cause(s) and mann date and place, and	ner as stated. d due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1 Nocoon) MI	29c. Licens	se number	3	7ehbr	Month, Day, Year) USYY 24,200
	3		30. Name and address of person who	completed cause of death (Item 23a) (Type.	Print) Dhi	instre	of Bal	timore	MD2AL
	Sta Regist		31. Date filed (Month, Day Bear) 5	2004 32. Registrar's Si	ignature	Souls.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 450N DICKERSON February 20, 11:00 A^M 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bayview Hospital Baltimore If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1ØM 2□F 80 Yrs. 213-20-6413 Director Jan 27, 1924 MD Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show rel', or items 23a or 28a-f shov Exactivational by notified at 1 Nes 2 No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Inportant if fine 27 is marked other then "naturel", or items 23a or any injury or other traumatic avant 5709 Adleigh Ave 21206 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Yes. Give Specify: 3 Widowed 4 Divorced Year or Dates: Black 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Dickerson Hallie Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susie Dickerson/Wife P.O. Box 11709, Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Feb 23 * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2004 Beltsville, MD 22. Name and Address of Facility
Cremation and Funeral Alternatives M00382 21. Signature 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE END **Physician** /Medical Due to (or as a consequence of) Examiner ASW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 21 ☑ No 2∏ No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 CER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar FFB 2 5 2004

		1 - For State Registrar	State of Ma	ryland / D	Department of H	ealth and M Death	fental Hygie	ene 200L	05839
Physic /Med Exami	ical	Decedent's Name (First, Middle, L CAF 4a. Facility Name (If not institution, g	ROL ive street and number)	ANN	DENICK 4b. City, Town, or	Location of Death	2. Date of Death Month February	Day Year 23, 2004 4c. County of Death	3. Time of Death 7:20 A
Funera Director		Greater Baltimor 5. Social Security Number 214-46-8071 Usual Residence of Decedent		(In yrs. last birt	Towson Hoday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	Baltimore 9. Birth 957	aplace (State or Foreign Intry) MD
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To the Hospital or Attanding Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as it	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigati		28b. T	njury Work	at Nursing Ho		ce 6 Other (Speci injury occurred	(5)
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7		30. Name and a dress of person who CARM Could War 31. Date filed (Month, Day, Year)	completed cause of dea	ath (Item 23a) (29c. License D Type, Print) CHALLET	ST. BA	LTIMOR	E, MD	2/284
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LTER DE	MMT	_ For	State of Maryla	nd / Depa	artment of I	lealth and N	lental Hy	giene 200	. nsol
		State Registrar		Ce	rtificate of	<u>Death</u>		rieg. No.	
Phys	ician	1. Decedent's Name (First, Middle, Last) WALTER CEPHAS					2. Date of De. Month	Day Year	3. Time of Death 12:08 Рм
	dical	WALTER CEPHAS 4a. Facility Name (If not institution, give	DENNIS		4b. City. Town, o	or Location of Death	FEB.	22, 2004 4c. County of Dea	
Exan	niner	1100 BOLTON PLACE				ORE CITY		И	
Funer		5. Social Security Number 6. Security Number 12.19-05-9738	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird Jan. 10	y, Year) Co	thplace (State or Foreign ountry) Yland
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r deat	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Ame Black, Whit	
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IIIU Z I Z I 3-0030 be filed within 72 hours after death with the Maryland hylygiene. d other than "natural" or items 23e or 28e-f show event, the Macilical Examinar must be notified at			Year or Dates:	16a. Dece	dent's Usual Occur	pation		16b. Kind of Business	
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r y ich	၉	Walter E. Denni 19a. Informant's Name/Relationship (Ty		Y 10h Mailir	Address (Street	Martha	Cepha		Tin Code)
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Deartiffication Pages Department of mportant: If it in injury or or	- Suce	21. Signature of Funeral Service License	00	_ 22	2. Name and Addre			uneral Ho	
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spitel ours a		29a. Certifier 1 ☐ Certifying Phys	sician: To the best of my kn	nowledge, death	occurred at the tir	me date and place	and due to the o	Cause(s) and manner as	stated
To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only XX Medical Examination)	ner: On the basis of examin and manner stated.	nation and/or in	estigation, in my o	ppinion, death occur	ed at the time, o	date and place, and due	to the cause(s)
To th withir To th	×	29b. Signature and title of certifier	A 1		29c. Licens	e number C.M.E	2	29d. Date signed (Monti FEB. 22	n, Day, Year) 2004
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Y		MARIAN	mpleted cause of death (Ite			Pal+imo-	Marca	land 21201	
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	1	ратглиот	e, nary	Tana SIZUI	
Regis		FFR 2 5 2004	Depense	13 1	Sparks!				

State of Maryland / Department of Health and Mental Hygiene 2004 05841 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 21, **Physician** February WILHELMINA JOHANNA ECKER 2004 3:50A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Keswick Home Baltimore N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 20, 1915 Birthplace (State or Foreign Country) **Funeral** 1 □ M 88 Vrs 317-05-6379 Director Indiana Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other treumetic event, the Medical Examinar must be notified at once. XXX 2 No Funeral Director Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 700 West 40th Street 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X X Vo If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Personel Utilities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Francis Ecker Johanna Scheidl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice M Leary Niece 5618 St Albans Way Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2**XXX** (Xemation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 2/24/04 Baltimore, Maryland Signature of Fun Licentile 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York ROad Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ope cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2days Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 24No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes ZZNo. Hospital: Cther: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Z Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 Na and averess of pe win who impleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 5

State of Maryland / Department of Health and Mental Hygiene 2004 05842 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year P M Billie Moomaw Eckard February 22, 2004 8:00 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner National Lutheran Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🂢 F 234-26-4742 82 Yrs. September 29,1921 West Virginia Director Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "neturel", or Items 23s or 28e-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ▼ No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6316 Carnegie Drive 20817 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: \$ Specify: White 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Institutes Elementary/Secondary (0-12) College (1-4or 5+) of Health Grants Clerk other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be is marked of Pages 1 and 2 should be Joseph Franklin Moomaw Malla Carolina Sine 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu once. / Daughter Lynda Eckard 5903 Jarvis Lane, Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February 26, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2004 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funeral/Service M01305 A. Keletes 23a. Part1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician aden CondiAC /Medical Due to (or as a consequence of): Examiner Coronal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in littated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed S bet 90 Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical the the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 No been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 🗀 Yes 250-No 1 Yes 2 No or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: Other ٩ ursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 1 Natural 2 Accident Division 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler completely (Check only one) To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D500612 eprony 23,2004 -M1 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel G. Maller, M.D. 3305 N. Leisure World Blvd., Silver Spring, Maryland 20906 31. Date filed (Houth Day, Year) FEB 2 5 2004 32, Registrar's Signature State Registrar 1 Aprile

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 20, 2004 February 8:15 AM Theodora G. Fitch /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Heritage Harbour Health Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpface (Stete or Foreign Country) **Funeral** Days Hours 1 M 200 F Yrs June 16.1910 Washington, Director 220-09-6732 93 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Show s 23s or 28s-f show 1 ☐ Yes 2 X No Maryland Anne Arundel Edgewater Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 101 Tarragon Lane 21037 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bfack, White, etc. r than "natural", or Items the Madical Examiner ma 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Anne Arundel County event, the Max Elementary/Secondary (0-12) 10th College (1-4or 5+) Circuit Court Deputy Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental F Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If I tem 27 is marked t any injury or other traumatic sw odes. 27 is marked c traumatic sve Carroll Lee George Hattie Dammeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7735 Mellow Ct., Gloria G. Ferguson/ Niece Hanover, MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Hillcrest Cemetery 2-23-04 Annapolis, MD 21. Signature of Fuffel Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospitel or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-Box 68760, Physician/Medical attending for use as fF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 4 Pregnant at time of death 5 Other (specify) o 9 Unknown Records, P. Part fl. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? eau 0 24a. Was an autopsy performed? Yes 21 No 2 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Tes 2 No 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title certifier 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE STEZZIANNAPOUS, M.D. HOPEA, M.D. LOCO RIDGELY 31. Date filed (Month, Day, Year) FEB 2 5 2004 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 05844 Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Februar 24 Philip 200A 0611 CFOY Fre an /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner VA MediCAL CENTER ALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APR 5, 192 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min 1 □ M 2 □ F 220-22-9363 75 Maryland Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Haaith and Mantal Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or flems 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🗓 No Maryland Baltimore Director Gwynn Oak 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1002 Sanbourne Road 21207 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify: þ White 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bernard Frey Ruth Lippert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mildred Frey/Wife 1002 Sanbourne Road Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages Department of Important: If its any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-25-04 Metro Crematory Inc. Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensep Momas Thomas Gregor 299 Frederick Road Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) YEARS Examiner Examiner physician and s the burial-transit The law requires that the daath certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): use as the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 Yes 2 No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 1 No cartificate Division of Vital To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, F. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 1 Yes 2 No 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 3□ DOA edical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Deeth 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

2 Madical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier P16553 Florwary 24, 2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ION GREENE STREET BALTINULE, MD 21201 ·SUN CARRIE 32. Registrar's Signature 31. Date filed (MorFEB Y2")5 2004 State marks Registrar

		•	1 - State Amend Item 10e p	State of Maryland / Dep er FH,G828,02/25/04dbb	partment of Health and Mertificate of Death	lental Hygie	ene 2004	05845
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici		DONALD	6IBSON		Month 02 2	Day Year	0633M
P 3 .	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death	0
			NORTH ARUND	EL HOSPITAL	GLEN BURNI	E	ANNEAR	UNDEL CO.
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	earl Coun	lace (State or Foreign
	Director		Usual Residence of Decedent	0 / 113		AUG, 23	1934 MA	RYLAND
	land ow		10a. State 10b. County	10c. City, Town or I	ocation		1	0d. Inside City Limits
	the Marylar 28a-f ehow	to	MARVIAIN ANNE ARC	WOEL CO.	GLEN BUR	NIE		1 ☐ Yes 2/≦No
	r 288	rec	10e Street and Number 7355 Furnace Branch R	d Fact	10f. Zip Code	10g	. Citizen of What Coun	try?
	th wit	Funeral Director	BELLE	GROVE ROAD	2106	0	451	7.
	r dea	ne	11. Waltar Olatas	Armed Forces?	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
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5-0036	hour tural	pe p	15. Decedent's Edu		edent's Usual Occupation	16	b. Kind of Business/Inc	dustry
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212	within right	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	RUCK DRIVER	2 6	WNER/OF	ERATOR
	othe	BeC	17. Father's Name (First, Middle, Last)	1	18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
lar	ould be filed with Mental Hygiene arked other the atic event, the	ToE	FRANK	GIBSON	MAR	1/	ARBO	1745
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mendal Hygiene, the hour fram 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at		19a. Informant's Name/Relationship (Ty	rpe, Print) 19b. Mai	ling Address (Street and Number or Run		1 -	
-	and and m 27	1	JAMES G. GI	BSON (BROTHER) 19	00 BENESCHCIR	7		10,21060
ore	ges 1 it of H or oth		20a. Method of Disposition Burial 2 Cremation 3 F	lemoval from State [ematory or other place)		c. Location - City or To	
Baltimore	permit. Page Department o Important: If eny injury or once.		'4 □Donation 5 □ Other (Specify)	MT. 210	The state of the s	27-04 1	ANSDOWNE	HARYLAND
3ai	permit. Pa Departmen Important: eny injury once.		21. Signature of Funeral Service Licens	99	22. Name and Address of Facility	SROUN	JK. FUNE	ERAL HOME
	40200		232 Part Foto the disease or comple	ications that caused the death. Do not en	nter the mode of dving, such as cardiac	TON FILE	, X3AL 10,	Approximate
			shock, or feart failure. List only of	ne cause on each line.				Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	YOCARDIAL I	NEARC	TISM 6	Munite
	Examiner			Due to (or as a consequence or).				
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	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	3.				
0	e exe ian ar irial-t		resulting in death) Last	Due to (or as a consequence of):				
9760,	certificate be executed iding physician and ise as the burial-transit	licai		d				
9 x	es that the death certifics igned by the attending pt be detached for use as t	Completed by Physician/Med	IF FEMALE:	3c. If yes, outcome of pregnancy				
Вох	death or e attend ed for us	ian/	in the past 12 months?	1 Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ny Day Year
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4	that the ed by th detache	h.	Part II. Other significant conditions co	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
Records,	requires een sign ould be	d b	CORONA	RY ARTERY	DISEASE	1 ☐ Yes	2 No 3 Prob	ably 4 Dunknown
Ō	× 0 70	lete				24a. Was an	24b. Were auto	osy findings available inpletion of cause of
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of Vital	Physician: The la r this certificate has aral director, page 2	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{Yes} \) No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	me 5 Residenc	e 6 Other (Specify	,)
0	ding Ph. h. After thi funeral	n:	27. Mann-Lineath Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how	injury occurred	
Division	Attending it death. ector: After by the funer	Certification:	2 Accident investigation		M 1 Yes 2 No			
ž	r Att ter de irect	ij	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, lactory, office	28f. Location (Stree City or Town, S	et and Number or Rura. State)	Route Number,
Ω	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Ce						
	Hosp 24 ho Fund fely f	edical		sician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.				
	ithin 2 tha	Mec	29b. Signature and title of certifier	and marrier stated.	29c. License number	29d	Date signed (Month, I	Day, Year)
	£ ≱ ∓ 8		1	15.00	055506		02/201	
•	0-		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type				
	13		Fer Ere M	109 Repe	Lie Hickory &	Endere	Maylon	1 2112
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	M. J			
	Regist	rar	FFR 2.5 2004	ACC SO A	()			

GIBSON DONALA

amend 10-16 per KB g830 4/1/04PleaseBType or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:42 PM **Physician** Michael Feb Gilmore J 004 12N /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of Maryland Medical Center Baltimore University If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Days **Funeral** Months Hours 1 XM 2 ☐ F Yrs. 6,2004 Maryland Director Usual Residence of Decedent 10el, Inside City Limits 10c. City, Town or Location 10a. State unk 10b. County ir then "natural", or iteme 23e or 28e-f ehow Ite Medical Exeminer must be notified at Yes 2 No Director Baltimore City unk 10g. Citizen of What Country? unk 10e. Street and Number 10f. Zip Code 21223 USA 2235 Ramsey St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education within 72 (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) infant infant none none othar 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be flit Department of Health and Menial Hy Important: If item 27 is marked oth any injury or othar traumatic event 17. Father's Name (First, Middle, Last) unk Be Melissa Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) UMMC 22 S. Greene Street Baltimore, MD Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State State Anatomy Board 655 W. Baltimore Street 21. Signature of Experal Singice Sicensee & Wade Baltimore, MD 21201 23a. Pal 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximale Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hypotension Physician 31 hours /Medical Due to (or as a consequence of): Examiner premat 31 hour treme Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed the burial-transit 31 hours Gram neg anve Due to (or as a consequence of Box 68760, nding physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ŏ in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached o. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, prenatal 1 Yes 2 No 3 Probably 4 Unknown Completed substance abuse 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No page 2 s autopsy performe Syphillis Maternal certificate 1 ☐ Yes 2 No of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA this 28c. Injury at Work? filled in by the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury Division 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide ŏ within 24 hours a
To tha Funaral C To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Strett, Baltimore MD 21201 S. FOX Kenee 22 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **FEB 2 5 2004**

DHMH 17 Rev 1/2001

Registrar

			For	•	yland / Dep		K. Ensure Al Health and M f Death	lental Hygi	ene annu	
		_	Registrar 1. Decedent's Name (First, Middle, Last)			erinicate o	Death	2. Date of Death	3. No. C U () L	3. Time of Death
	Physici	an	Edna Griffin					/ Menth	Day Year	1 1 22 W.
	/Medic		4a. Facility Name (If not institution, give s.	treet and number)		4b. City, Town	, or Location of Death	TEDRURRY	4c. County of De	
	Examin	er	LORIEN @ RIVERS			BI	ELCAMP	/	HARFOR	D
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda		ar If Under 24 Hrs.	8. Date of Birth (Month, Day,	(ear) 9. B	rthplace (State or Foreign
	Director		253-34-6726 ¹	M 25€F	83 Yrs.	Worth Day	S TIOUTS IVIII.	10/22/1	920 GA	1
	pu 🛊		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or	Location				10d. Inside City Limits
	Aarylé r sho	5	MD Harford		Bel Air					1 ☐ Yes ZONo
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fijury or other traumatic avant. The Madical Exaction or than the notified at Once.	I Director	100 Skeet and Number 2216 Quail Creek	Ct.		10f. Zip Code 21	015	10	g. Citizen of What C USA	Country?
	death	Funeral	11. Marital Status	2. Was Decedent Ev	er in U.S. 13	B. Was Decedent of	f Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No-	14. Race - Arr Black, Wh	
9	or its	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give		1 Tes, specify Ci		rticali, etc.)	Specify:	White
ဗ္ဗ	ours irai',	Completed by	3 XWidowed 4 ☐ Divorced	Year or Dates:						
<u>7</u>	72 h "natu	ete	15. Decedent's Educ (Specify only highest grade	eation completed)	16a. Dec	edent's Usual Occ ye kind of work dor	cupation ne during most of work ired)	ing 1	5b. Kind of Busines	s/Industry
7	within and the state of the sta	d E	Elementary/Secondary (0-12)	College (1-4or 5+)		nemaker	160)		Own Home	
2 2	Hygie thar int.	ပိ	17. Father's Name (First, Middle, Last)		TIO	ikilakei	18. Mother's Name	e (First, Middle, M		
an	d be ental	To Be	Henry Daniel				Ruby R	obinson		
Baltimore, Maryland 21215-0036	shoul nd M	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Ma	iling Address (Stre	et and Number or Run	al Route Number,	City or Town, State,	Zip Code)
ž	nd 2 alth a 27 is	n g	Kimberly Hoerr	Daughter	2216	Quail C	Creek Ct. E	Bel Air,	Maryland	21015
ē,	f Heri	1 8	20a. Method of Disposition			position (Name of		0ate 26	Oc. Location - City of	r Town, State
Ĕ	Page nent ont: If		1 Burial 2 □ Cremation 3 □ Ri 1 □ Onation 5 □ Other (Specify)	emoval from State	Parl	titis men	DITAL 02/2	.0,04 E	lberton,	GA. 30635
aĦ	Ports		21. Signature of Fun - Service License	99		22. Name and Add	dress of Facility Cva	ch/Rosed	ale Funer	al Home
<u> </u>	89 = 89		10%			LZII Ches	aco Ave Ro	<u>sedale M</u>	D_21237	
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final						st,	Approximate Interval Batween Onset and Death
	Physician /Medical		disease or condition resulting in death)	/V	40 (and	MOY /1	tarch'or			
ш	Examiner			Due to (or as a	consequence oi):	merls.	maideli	1		3 miles
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	1 June	2 000	<u> </u>	,	D TOVOTAS
/	d d ansit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events							
, 0	e be executed /sician and e burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
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89)	death certificate be attending physion of for use as the beattending physion of the beat the beat the beat the beat the beat at the beat t	Med	IF FEMALE:							
Вох	ath ce ttendi or us	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	Fetal death	BEctopic pregna			23d. Date of d Month	elivery Day Year
	0 0 0	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at ti 9☐ Unknown	me or death	5 ☐ Other (specify)				
P.O.	The law requires that the de ate has been signed by the a bage 2 should be detached t		Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying cause	given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ds,	w requires t been signe should be	d by	War terisa	-				1 □ Yes	2 0 1 3 □ 1	Probably 4 Unknown
Ö	v requ been shoul	Completed	- IF YI					24a. Was an	24b. Were	autopsy findings available
Rec	The lav	Ę						autopsy	ed? death?	completion of cause of
ja		C	25. Was case referred to medical				26 Place of Deat	1 ☐ Yes 2* th Check onlone	00	es 2 No
of Vital Records,	Physician: this certificanal director, I	To B	evaminer?	lospital:	2 ER/Outpat	ient 3 DOA	Other		nce 6 Other (Sp	ecify)
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Ö	uttandin death. ctor: Aft y the fur	atio	1 Natural 5 Pending 2 Accident investigation	(, 2-2)		,	☐Yes 2☐No			
Division	Il or Attanding Pafter death. I Diractor: After to in by the funers	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.		street, factory, office	СӨ	28f. Location (Stre City or Town,	eet and Number or i State)	Rural Route Number,
۵	To tha Hospital or Att within 24 hours after d To the Funaral Diract completely filled in by		29a. Certifier 1 Certifying Phys	sician: To the best of	my knowledge, de	eath occurred at the	time, date and place,	and due to the car	use(s) and manner	as stated.
	ha Ho in 24 ins Fu	Medical	one)	and manner state	ed.		y opinion, death occur			
	To t To t	Σ	29b. Signature and title of certifier	MAA.	1 4 6	29c. Lice	ense number	29	d. Date signed (Mo.	nin, Day, Year)
	6		MU	vous 1	ul	nt	7975		2/22/0	4
	V)		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type	O	a nel	Lal An	MM 2	1614
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	MCC Mus	1 /10 /1	- Inn	2-01 VIC	(
	Regist		EED 9 5 200A	<i>A.</i> >	to A					

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			1 - For State Registrar	State of Maryla	nd / Dep <i>Ce</i>	artment of H	ealth and Modern	fental Hygie	ene 200	4 05848		
₇ /1	ysicia Medica kamine	al	Decedent's Name (First, Middle, Last) Catherine Cas 4a. Fecility Name (If not institution, give s	lin Gill treet and number)			Location of Death	2. Date of Death Month February	23, 2004	th		
Dire	neral ector		Catered Living 5. Social Security Number 218-03-9717 Usuel Residence of Decedent		. last birthday) Yrs.	COCKEY If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y June 27,		thplace (State or Foreign ountry) Yland		
Deficiency, Interpretation 2 12 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show	ant, the Medical E	To Be Completed by Funeral Direct	10b. County Maryland Baltimore 10e. Street and Number 10883 York Road 11. Marital Status 1 Never Married 2 Married (Specify only highest grade Elementary/Secondary (0-12) 12. Tather's Name (First, Middle, Last) John 19a. Informant's Name/Relationship (Typ. Stacey Gill Jacobs 20a. Method of Disposition 1 Meurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	ng Address (Street a	spanic Origin? (Spin, Mexican, Puerto Specify: ation uring most of works 18. Mother's Name Ethel and Number or Rure ace Summe	acify Yes or No-Rican, etc.) Ing Ing First, Middle, Ma Al Route Number, Carville,	g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 6b. Kind of Business/Industry Retail aiden Sumame) Eicholtz City or Town, State, Zip Code) South Carolina 29485 Oc. Location - City or Town, State					
Physic /Med Exami	cian lical iner	ical Examiner	22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 Approximate interval Between Conset and Death of the properties of the									
hat the death certifica by the attending ph	e detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contiled.	23d. Date of delivery Month Day Year 20 use contribute to the cause of death?								
in: The law requires t		completed	ARTER 10 SCCEROTT C	9m0100A3	CULAR			1 Yes 24a. Was an autopsy performed 1 Yes 2	24b. Were au prior to death?	topsy findings available completion of cause of		
# Attending Physician: The lax fer death. irector: After this certificate has	the state of	2	examiner?	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At h building, etc. (Specia	ER/Outpatien 28b. Time of Injury ome, farm, stre	28c. Injury Work?	at 2	ne 5 Residence 8d. Describe how	njury occurred t and Number or Ru	ral Route Number,		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	pletely fill	Calca	29a. Certifier 1 Certifying Physi	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge death	occurred at the time restigation, in my opi	e, date and place, a nion, death occurre	and due to the cause	o(s) and manner so	stated. to the cause(s)		
To ti withi.	i i i i i i i i i i i i i i i i i i i		29b. Signature and title of certifier 30. Fame and address of Prison who com BARRY JJJ FAR			-	637		Date signed (Month 2/23/04 2/204	* * * * * * * * * * * * * * * * * * * *		
Re	State gistra	1	31. Date filed (Month, Day, Year) FEB 2 5 20	32. Registrar's Signa	iture	books						

State of Maryland / Department of Health and Mental Hygiene 2004 05849 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month William **Physician** GAINES 0930 ROV /Medical 4b. City, Town, or Location of Death 4a Fecility Neme of not institution, give street and number) 4c. County of Death Examiner BALL, MURE BALTIMORE VA MEdiCAL CENTER NIA If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days **☆**□ M 2□ F Director 4343 JAN.21,1921 MISSISSIPPI 493 44 Usuef Residence of Decedent Pegas 1 end 2 should be filed within 72 hours aftar death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Health end Mentel Hygiene. tem 27 is markad other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at N/A 1X Yes 2 □ No BALTIMORE Director MD. 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 1516 POPLAR GROVE ST. 21216 U.S.A. Was Decedent Ever in U.S. Armed Forces?

13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?

15. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?)

15. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces)

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18. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces)

19. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces) Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Maritaf Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 2-08-46 1 Yes 2 No 3altimore, Maryland 21215-0020 Specify: BLACK þ 3 ₩idowed 4 Divorced Year or Dates: Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coflege (1-4or 5+) Elementery/Secondary (0-12) 12TH MINISTER FAITH BAPTIST CH. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) B EMANUEL GAINES PHEBE Watson 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health e important: If Item 27 is any injury or other tra once. MARTHA L. MITCHELL (SISTER) 1516 PoplarGROVE ST. BALTO, MD. 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition GARRISON FOREST VETERANS CEM. OWINGSMILLS, MD. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME E. PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Perforated CoLON /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner attending physician end for use es the buriel-trensit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ONStiPATION 2VNO 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 11 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ this Director: After thi d in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pendina 1 Natural 1 ☐ Yes 2 No death. investigation 223-04 21004 Complication of Colonoscop 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide fillad in t Hospital or BALTIMORE VAME ION GREENE ST HOSP: HAL within 24 hours a To the Funersi Completely filled edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a, Certifier (Check only To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P16446 ~1 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 10N. GREENE STREET BALLINURE MB 21201

DHMH 16 Rev 6/95

State Registrar

Richard 31. Date filed (Month, Day, Year)

FEB 2 5 2004

Registrar's Signature

		For State Registrar	State of Marylan	nd / De		Health and	•	vaien	_	+ 05850	
		Decedent's Name (First, Middle, I	ast)				2. Date of D	Death		3. Time of Death	
Physician /Medica	al .	Mary Juell Ga			4b. City. Town	, or Location of Dea	Febru	ary	20, 2004		
Examine	r	Brooke Grove Nu				Spring			Montgome		
Funeral			Sex 7. Age (In yrs.	last birth	day) If Under 1 Ye	ar If Under 24 Hr		lieth	Q Rist	hplace (State or Foreign untry)	
Director		440-26-8179	1□M 2\\ F 86	Yı	rs. Months Day	rs Hours Min	April	1,	1917 Okl	ahoma	
pu s	-	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	tv. Town	or Location					10d. Inside City Limits	
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the h	Director	Maryland Montgo 10e. Street and Number	mery Sa	inay	Spring 10f. Zip Code			10a. C	Citizen of What Co	untry?	
permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show eny injury or other traumatic event, the Medical Evanthar must be notified at once.	5	18131 Slade Sch	nol Road		20860				ited Sta		
ms 2	Completed by Funeral	11. Marital Status	12. Was Decedent Ever in U	.s.	13. Was Decedent of If Yes, specify C		Specify Yes or N		14. Race - Ame	rican Indian,	
or its	ב ב	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give		1 Yes, specify C		no Hican, etc.)		Black, White	e, etc.	
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natu dea	ete	15. Decedent's (Specify only highest of		16a. D	Decedent's Usual Occ Give kind of work dor life. DO NOT use reti	cupation ne during most of wo	orking	16b.	Kind of Business/	Industry	
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o de la companya de l	e Re								,		
mari mari	0	William P. Little Florence E. Dooley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2									
27 is 27 is r trau	1	John H. Swagger	/Friend	70	88 Saddle	Drive, S	kesvill	e. N	Marvland	21784	
iten othe	4	20a. Method of Disposition			Disposition (Name of crematory or other p		Date uary 21	+	Location - City or		
nt: #		1 ☐ Burial 2 🖾 Cremation 3 `4 ☐ Donation 5 ☐ Other (Special)	□Removal from State Moř city)	ntgon	nery orium, Inc	2004	-	Bet	hesda, M	arvland	
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ysician		Immediate Cause (Final disease or condition	. Chronic R	lena1	Failure					Onset and Death 5 Years	
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Sit.	lue lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq								
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use a	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		د العالم العالم العالم العالم العالم العالم العالم العالم العالم العالم العالم العالم العالم العالم العالم الع				23d. Date of delin	very	
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After	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Tin Inju	iry W	juryat /ork? ∐Yes 2∐No	28d. Describe	now inj	ury occurred		
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within 4 Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) Certifying I	Physicien: To the best of my kno eminer: On the basis of examina and manner stated.	wledge, o	death occurred at the or investigation, in my	time, date and plac y opinion, death occ	e, and due to the urred at the time	e cause(:	s) and manner as nd place, and due	stated. to the cause(s)	
within 2 To the comple	ĕ Z	29b. Signature and title of certifier	and mainer States.		29c. Lice	nse number		29d. Da	ate signed (Month	, Day, Year)	
- 5		Wilkens	Nikkum J. Ninal D45285 February 20.								
20		30. Name and address of person wh	o completed cause of death /Item	n 23a) (Tv				reb.	ruary 20,	, 2004	
		Wilkinson Ninal				evard Wes	t, #113.	, Si	lver Spr	ing, MD 2090	
State	e	31. Date filed (Month, Day, Year)	2. Registrar's Signa		matte 1		,				
Registra		CED 9 5 701	VA VIGALES SI	450	ALL COLOR						

State of Maryland / Department of Health and Mental Hygiene 200 L 05851 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:30 P February Chester Goodman, Jr. 20, 2004 Irvin /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 712 W. Baker Avenue Abingdon Harford 8. Date of Birth (Month, Day, Year) NOV. 12, 3 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 192-26-7917 68 1935 Virginia Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Harford Abingdon Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with itams 23a 712 W. Baker Avenue 21009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1957-60 1 ☐ Yes 2X No Specify: Black ģ 3 Widowed 4 Divorced naturei Completed the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Construction Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nt of Health and Mental H

1: If Item 27 is marked oth

y or other traumatic even Be Chester Goodman, Sr. Katie Mae Wimbish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maelyn M. Goodman - Wife 712 W. Baker Avenue, Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Burial 2 Cremation 3 Removal from State permit. Page Department Important: If any injury or Bel Air Mem. Gardens 2-27-04 * 4 □ Donation 5 □ Other (Specify) Bel Air, Maryland 21. Signature of Fundal Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that cashock, or heart failure. List only one cause on particular that the complete state of the cause of the cau Approximate Interval Between Opset and Death used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** BRAIN METASTASIS /Medical Due to (or as a consequence of) Examiner dung Securations is constront if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons of nce of): or Attending Physician: The law requires that the death certificate be executed burial-transit Exami VILOTINE and Due to (or as a consequence of): Box 68760 the attending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ğ Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. detached 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ N Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page death? 1□ Yes 2□ No 2 \(\text{No}\) Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 1080 Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 CHURCHVILLERd. 5000 MO. Md 21014 1208 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 5 2004 Registrar

lza M	BETH G	KEK	5/3	Please	Type or Pr	int in Blac	ck Inde	lible Ink	. Ensure	All Copie	s Are Le	gible.	
			1 - For State Registrar		State of M	faryland /	Depart Certin	ment of I	Health and Death	Mental H	ygiene 2	004	0585
	Dhunini		1. Decedent's Nar	ne (First, Middle, L.	ast)	-				2. Date of I	Death Day	Year	3. Time of Death
	Physici /Medi		Elizabe	eth Greg	g					FEBRU	JARY 20	, 2004	10:50 P ^M
	Examir		4a. Facility Name	(If not institution, gi	ve street and number	r)	4	b. City, Town,	or Location of Deat	h	4c. Co	unty of Death	n
				SPRING ST					MORE CITY		N/A		
*	Funeral		5. Social Security		Sex 7. A 1 ☐ M 2 ☐ 1 €	ige (In yrs. last b	N.	f Under 1 Year Ionths Days			Birth Day, Year)	9. Birth	nplace (State or Foreign untry)
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	and *		Usual Residence	10b. County		10c. City, Tov	wn or Locat	ion					10d. fnside City Limits
	/anyl	ō	MD	27/2									1 ☐ Yes 2 ☐ No
	within 72 hours after death with the Maryland ane. than "natural", or Itams 23a or 28a-f show he Madicial Examinar mail be notified at	Funeral Director	10e. Street and N	N/A umber		Balti		10f. Zip Code			10g. Citizen	of What Cor	untry?
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	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If itsm 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avent, the Medical Examiner mail be notilized at		Mrs. Ma	hallie Ca	nty-Siste		7716	Bender	Road, La	ndover.	MD 207	85	
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alt	permit. Pages Department of Important: If i any injury or ones.		21. Signature i F	uneral Service Lice	nsee	(22. N	ame and Addr	ess of Facility				
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S,	igned be de	by F	Part II. Other sign	ificant conditions	contributing to death	but not resulting	in the unde	rlying cause gr	ven in Part I.	23e. Dio	tobacco use c	ontribute to	the cause of death?
rd	w require been signationships	ed								10]Yes 2□No	3 ☐ Pro	bably 4 Unknown
Records,	aw requisible bear	Completed								24a. Wa		b. Were aut	opsy findings available
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	ng Phys ter this neral di	n: T	27. Manner of Dea		28a. Date of In		. Time of Injury	28c. Inju	ry at	28d. Describe	e how injury oc		SCEIVE
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	With To t	Σ	29b. Signature an	d title of certifier	2			29c. Licen:	se number		29d. Date sig	ned (Month,	Day, Year)
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	Regist	ar	FE	B 2 5 200	4	13	17						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 05853 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 18 10:46 PM 2004 300 /Medical 4c. County of Deeth 4a. Facility Name (# not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Care 3707 Egarton Rd Janor Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey, Funeral 1 M 2 F 227-14-6757 Director 1-12-1906 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. and to them 27 is marked other than "natural", or flema 23a or 28a-1 show arry or other treumatic event, the Medical Exambles in the De notified at 1 Pes 2 Na Baltimore Director MU 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 212 3701 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 € No Baltimore, Maryland 21215-0036 Specify: Specity: Black 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7+4 Domest 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DANIEL Green A Green ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto CALVIN Son 3707 20b. Place of Disposition (Namb of cometery, crematory or other place) Date 20c. Location - City 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Sacred Heart * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wesley Chay: 551. 2007 Eastern 21. Signature of Funeral Service Licensee AVE 23a. Part. Enter the disease or complications, at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) resor vans **Physician** /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed terles Due to (or as a uence of): Division of Vital Records, P.O. Box 68760, Disease Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 2 No 3 Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 1No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Alter this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 314 2/23104 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balt - MD 2120 Inte JOE 21 N, EVITAGE ST 32. Registrar's Signature 31. Date filed (Month, Day, Year) State medi Registrar FEB 2 5 2004

			1 - For Amend Item 4c Registrar	State of M per DVR,02/	aryland 25/04d	d / Depa hb <i>Cel</i>	artment rtificate	of He	ealth ar Death	nd Me	ental Hy	giene Reg. No	200) 4	05854
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Mary and 2 shou	27 la mar r traumat		19a. Informant's Name/Relationship (Type, Print) Janice Hudson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, 5 1635 Deer Meadow Ct. Hanover, Maryland 21076 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - C											te, Zip (Code)
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Balt Permit.	Import eny inj		22. Name and Address of Facility Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
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VISION OF VITAL Attending Physician:	or: After th	Certification; 7	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Inj (Month, Da	ury	28b. Time of Injury		Injury a Work?		280	d. Describe I			spoony	
DIVE	ral Direct		3 Suicide 6 Could not be determined	building, e	tc. (Specify))					City or Tov	m, State)			Route Number,
To the Hospital	To the Funeral	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best niner: On the basis of and manner s	of examination	vledge, death on and/or inv	occurred at estigation, in	the time my opir	, date and p nion, death o	occurred	due to the at the time,	cause(s) date and	and manne place, and	r as stat due to th	ed. ne cause(s)
To th	To ti	Σ	29b. Signature and title of certifier				29c. l	icense r				29d. Date	e signed (M	onth, De	y, Year)
		-	30. Name and address of person who	completed cause of	death (Item	23a) (Type 1	Print)	15	893	_ر		2	20	04	
	7		Andrew Sarchia	apone, N	CI	16S.		w.	Stree	+ 1	Baltin	more	2, Mi	<u> </u>	1001
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 5 20	32/Regist	rar's Signatu	иге	we will								

DORIS HICKS 04 - 1358DAP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? [] [] [] - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer Month **Physician** HICKS FEBRUARY 20,2004 DORI 10:48p /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE CITY SINAI HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Min. PAROLINA Months Hours 1 M 2 F 220-18-510 6 NORTH(Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, Ira Madical Exercities invalibe rediffical at once. 1 Yes 2 No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 20 10 EXINGTON SI. 1.5A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baitimore, Maryland 21215-0036 BLACK Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname) Be GERMAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SISTER MARY TIMONIUM MD MARCUS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State ZION ANSDOWNE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BROWN FUNERAL PH ULTON AVE. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPERTENSINE ATHEROSCIENTIC CARDIOVASCUM DISEASE **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 No be detached of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DISRASA 3 Probably 4 Unknown 1 Tyes 2 No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? DISEASE page 2 has 2 No 2 200 1 Yes 25. Was case referred to medical examiner?
1 \(\overline{\text{X}} \text{Yes} \quad 2 \square \text{No} \) funeral director 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title OCME FEBRUARY 21,2004 eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp 111 Penn Street, Baltimore, Maryland 21201 (32. Registra Signature 31. Date filed (Month, Day, Year) State 2 5 2004 FEB

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 05856 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** le Michael chrun 22 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner gad bor Bal Ol ha TMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5/25/1955 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** Days Min 216-62-1916 1 ☑ M 2 ☐ F 48 Director MD Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f ehow the Medical Examiner must be notified at MD N/A Baltimore City 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1537 Marshall Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2€ Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: þ white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 s 1 and 2 should be filed w I Health and Mental Hygier Item 27 is marked other th 0 Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles M. Hunt, Sr. Marie (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar important; if item 27 is any injury or other trau Wanda L. Hunt / Wife 1537 Marshall Street, Baltimore MD 21230 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify) Entantment Loudon Park Cemetery February 27, 2004 Baltimore MD Charles L. Stevens Funeral Home, Inc. 21. Signature of Funeral Service License Victor P. Doda, Jr. 1501 Fast Fort Avenue, Baltimore MD 21230 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Van Maulas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner dia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed use as the burial-transit 0/019/1 and resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ned by the a detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s has autopsy performed? certificate 1 Yes 2) No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 1 ☐ Yes 2000No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification; Division Hospital or Attending 1 Natural Injury 5 Pending Vithin 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and fitte of certifier 29d. Date signed (Month, Day, Year) 0052022 eted cause of death (Item 23a) (Type, Print) 30. Name and address of person 3001 South Hanover Street 10 32 Registrar's Signature State 2004 Registrar

		•	For State Registrar	State of Maryland	/ Depa <i>Cer</i>	irtment of F tificate of	lealth and Death	Mental Hy	giene 2 (004	05857		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Amalene E. Ho	umilton				2. Date of Dea Month February		2 0 0 4	3. Time of Death 9:35A M		
	Examin Funeral Director	er	4a. Fecility Name (If not institution, give support of the security Number 407-30-9201	7. Age (In yrs. last	birthday). 7 Yrs.	4b. City, Town, of Elktov. If Under 1 Year Months Days	L If Under 24 Hrs Hours Min	s. 8. Date of Birt	r. Yeer)	9. Birthpl Coun	lace (State or Foreign try) (ENTUCKY		
	D	7	Usual Residence of Decedent 10a. State 10b. County	10c. City, T					, ,,,,,		0d. Inside City Limits 1 XYes 2 □ No		
	with the M a or 28a-f Lbe notifie	Director	MD Cecil 10e. Street and Number 23 Benjamin Lane	Kis	ing S	Sun 10f. Zip Code 219)11		10g. Citizen of V	Citizen of What Country?			
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23s or 28s-f show enty injury or other traumatic event, its Medical Examinat must be notified at ODGs.	by Funeral		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:				Specify Yes or No- nto Rican, etc.)	14. Rad Blad	ce - America ck, White, e y: Whit	an Indian, etc.		
Maryland 21215-0036	within 72 hou ene. then "netura he Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)			lent's Usual Occup kind of work done DO NOT use retired Lacher	eation during most of wo	orking		find of Business/Industry Lic elementary			
land 2	ld be filed ental Hygi ked other Ic event,	To Be Co	17. Father's Name (First, Middle, Last) James Elliott	i				ume (First, Middle, 24 Henson	Maiden Suman	пө)			
Mary	and 2 shoul alth and M 27 le marl er traumati		19a. Informant's Name/Relationship (Ty, Thomas Hamilton/hu				and Number or R	Sing Sun,	r, City or Town,		Code)		
Baltimore,	t. Peges 1 a rtment of Her rtent: If item njury or othe		20a. Method of Disposition 1 Burial 2 XCremation 3 R 4 Donation 5 Other (Specify)	20c. Location - Rising	Sun.	MD 21911							
■ Bal	Depa Impo		21. Stradure of Funeral Service License 23a. Panl. Enter the disease, or complishopk, or heart failure. List only or	Goodie	1 1	11 South	Queen S	.T. Foard t., Risin	g Sun,				
	Prysician /Medical Examiner	Examiner	Immediate Cause (Final disea or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	Due to (or as a consequent)	ce of):					ő	Interval Between Onset and Death 27 y 2a VS		
Box 68760,	eath certificate be executed attending physicien and for use as the burial-transit	edical	23b. was decedent pregnant	Due to (or as a consequent 3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	te of delive								
P.0.	oy the ached	1 Yes 2 Mo									Month Day Year o use contribute to the cause of death?		
ecords	e law requires that has been signed b je 2 should be det	Completed by	Metastatic to Lings 1 Yes 2 PNO 3 Probably 24a. Was an 24b. Were autopsy fi										
/ital Ro	cian: The ertificate ha	Be	25. Was case referred to medical examiner?	la control				autop perfor 1 Yes	med2 2 No	death?	npletion of cause of		
Division of Vital Records,	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 ER 28a. Date of Injury (Month, Day Year) 28	Outpation b. Time of Injury	28c. Injur Wor	4 Nursing	Home 5 Resid)		
Divis	oltel or Atteurs after degral Directoried in by the	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify)	- At home, larm, street, factory, office 28f. Location					(Street and Number or Rural Route Number, own, State)			
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physical Exeminates (Check only one) 2 Medical Exeminates (Check only one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	est of my knowledge, death occurred at the time, date and place, and due to its of examination and/or investigation, in my opinion, death occurred at the ristated. 29c. License number					o the cause(s) and manner as stated. time, date and place, and due to the cause(s) 29d. Date signed (Month, Dey, Year)			
)	5			erchor h. ms	Sa) (Tuna	D	44313		Februry				
	Sta	te	Joseph K. Weidner 31. Date liled (Manny Day, Zeary 2)	. Jr. MD 101 Co	loni	al Way. F	Rising Sl	Un, MD 21	911				
	Regist		1 1 0 0 200	4 32 Registrar's Signature	1	Wil							

State of Maryland / Department of Health and Mental Hygiene 2004 05858 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day Vear **Physician** Dorothy Nea1 Hunt 204 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deet 4c. County of Deeth **Examiner** Age (In yrs. last birthdey) f Under 24 Hrs 5. Social Security Number If Under 1 Year Birthplece (Stete or Foreign Country) **Funeral** Months Devs Hours 1 □ M XX F 220-07-0994 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Maryland Harford 1 ☐ Yes 2 No **Funeral Director** Belcamp 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1123 Belcamp Garth 21017 United States 11. Marital Status 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XX No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ş 3 Widowed 4 □ Divorced white Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be tiled within Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alfred Garfield Neal, Sr. Ethel Beulah Chaney 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edmond R. Hunt, Jr./son 1400 MarlowCt. Belair, MD 21014 20a. Method of Disposition
1 ☐ Burial 2 DCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ò 2/24/04 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Greenmount crematory 22. Name and Address of Facility ${
m Mitchell-Wiedefeld}$ Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6500 York Rd. Baltimore, MD 21212 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) by Physician/Medical Examiner or Attending Physician: The law requiras that the death certificate be executed use as tha bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 DNo 3 ☐ Probably 4 ☐ Unknown pomic To the Hospital or Attending Physician: The law requiras tha within 24 hours aftar daath.

To the Funeral Director: After this certiticata has been signed completaly tilled in by the funeral director, paga 2 should be de 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 21/2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 200 No Other: Certification: To 1 ☐ Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) Medical 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) an muri 31. Date filed (Month, Day, Year) FEB 2 32. Registrar's Signature State Registrar

				State of Mar	vland / Den	artment of h	lealth and i	Mental Hydi	ene 2004	
			for State Registrar	Olato of mar	Ce.	rtificate of	Death	Re	g. No. 2004	05859
	Physici	20	1. Decedent's Name (First, Middle, Last	")				2. Date of Death Month		3. Time of Death
	/Medic		Catherine		Haw	kins		Feb. 2	2, 2004	11:15 Mm
	Examir	er	4a. Fecility Name (If not institution, give 2611 Crabapp				or Location of Deatl	ו	4c. County of Death	
	Funeral		5. Social Security Number 6. Se		In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth	N/a 9. Birth	place (State or Foreign ntry)
и	Director		217-12-0712	□M 280 F 9	7 Yrs.	Months Days	Hours Min.	(Month, Dey, Sept 2	1,1906 M	laryland
	land wo		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Mary a-f eh	ţōţ	MD N/A		Balt	imore				1 Yes 2 □ No
	ith the	by Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	• 23•	rall	2611 Crabapp	ole Rd		21212			U.S.A.	
, o	fler de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 🕅 No	er in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
8	rel', or	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:		Specify: Bla	ck
5	filed within 72 hours after death with the Maryland Hygiene. yther than "naturel", or Iteme 23e or 28e-f ehow ent, the Mudical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	(Give	dent's Usual Occup	during most of wor	king 1	6b. Kind of Business/In	ndustry
7	withir lene. than	dwo	Elementary/Secondary (0-12) 3rd	College (1-4or 5+)	IITe.	DO NOT use retire			DATEROAR	
פ	should be filed within 72 hours after death with the Marylan ad Mental Hygiene. marked other than "naturel", or Iteme 23e or 28e-f ehow marked other than "naturel", or Iteme 23e or 28e-f ehow market event, the Mudical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)			VATURO		ne (First, Middle, M	RAILROAD aiden Sumame)	
ylar	should b and Menta marked	To	John Young				Irene	Brise		
Maryland 21215-0036	2 4 5 5		19a. Informant's Name/Relationship (7)						City or Town, State, Zip	Code)
	Health tem 27 other tr		Rosa White/Gr 20a. Method of Disposition	anadaugnt	20b. Place of Dispo	sition (Name of			Md 21212 Oc. Location - City or To	own. Stete
Ë	Pages Tent of Int: If it		1 Burial 2 Cremation 3 F '4 Ponation 5 Other (Specify)			natory or other planting idge Ce			04 Pikesv	
Baltimore,	permit. Pages 1 an Depertment of Heal Important: If item 2 eny injury or other once.		21. Signature of Funeral Service Licens	99		Name and Addre	ss of Facility			
	405 a		In moderne	Ch AUM	Alf I	412 E.	PRESTON	ST. BAI	RAL HOME LTO.MD 21	
E	Obveision		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.				or respiratory arres	St,	Approximate Interval Between Onset and Death
2	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a c		DEIVLE	-NT) A			
	Examiner		Sequentially list conditions.	. AST	MA					
	bed sit	ulnei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):					
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x 68	The law requires that the death certificat te has been signed by the attending phy sage 2 should be detached for use as th	Physician/Med	IF FEMALE:	32- 16						
Box	leath certifi attending I for use as	clan	in the past 12 months?	3c. If yes, outcome of 1☐Live birth 2 (4☐Pregnant at tirr	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of deliver Month	ery Day Year
л О	at the de by the a	hysl	1 Yes 2 No 9 Unknown	9□ Unknown						
	w requires that been signed b should be deta	by	Part II. Other significant conditions con			nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
org	requir	eted	DECABIL	S UL	JE12S			1 Yes	2No 3□Prob	ably 4 Unknown
Hecords,	The law sate has t page 2 s	Completed						24a. Was an autopsy performe	prior to cor	psy findings available impletion of cause of
_		Be Co	25. Was case referred to medical				26 Place of Dear		No 1 □ Yes	2 No
2	hysici his cer I direc	To B	examiner? 1 \(\text{Yes} 2 \text{No} \)	lospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Oth			ce 6 Other (Specify	<i>y</i>)
ב	iing Ph After th Iuneral	on:	27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	28b. Time of Injury	Wor		28d. Describe how	injury occurred	
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	To the Hospitel or Attending Physician: whith 24 hours after deals as after deals. To the Funeral Director After this certifical completely filled in by the funeral director,		Check only 2 Medicel Exemil	sician: To the best of n	ny knowledge, death	occurred at the tin	ne, date and place,	and due to the cau	se(s) and manner as st	ated.
	o the ithin 2 o the omplet	Medical	29b. Signature and title of certifier	and manner stated		29c. Licenso			I. Date signed (Month, I	``
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			31. Date filed (Month, Day, Year)		C. 244	76N.	HARLE	s ST B	ALTMORE	1521218
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	•	For State Registrar	State of Ma	aryland .	/ Depa <i>Cer</i> t	rtment of tificate of	Health and I Death	Mental Hyg	iene og. No.	2004	05860	
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Director		212-38-2622	M 2A1	89	Yrs.			Oct. 11	, 191	4 Mary	land	
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the A	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cor	untry?	
iled within 72 hours after death with the Maryland Hygiene. thygiene. ther then "natural", or flems 23a or 28s-f show on, the Medical Examilier must be notified at out, the Medical Examilier.	ā	13801 York Road				21030			USZ	A		
Jeath ms 23	Funeral	11. Marital Status	2. Was Decedent	Ever in U.S.	13. W	Vas Decedent of	Hispanic Origin? (S	pecify Yes or No-	14	Race - Amer		
r Her	F	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 24	No	l l	Yes, specify Cl	o Specify:	o Hican, etc.)		Black, White		
E Sur S	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			LITES ZEIN	о зресну.		5/	pecify: Wi	nite ——————	
72 hours natural',	Completed	15. Decedent's Educ (Specify only highest grade		1	16a. Decede (Give k	ent's Usual Occ	upation se during most of wor red)	rking	16b. Kind	of Business/I	ndustry	
ithin	ldu	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	OO NOT use reti	red)					
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should be nd Menta marked umatic ev	2	19a. Informant's Name/Relationship (Ty)			10b Mailine	a Address (Stra	et and Number or Ru					
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		James Hoopes - So									ryland 21050	
s 1 and 2 f Health frem 27 other tra		20a. Method of Disposition		20b. Plac	e of Dispos	sition (Name of	1	Date		tion - City or		
permit. Pages Department of the important: If ite any injury or of once.		1√2 Burial 2 □ Comation 3 □R	emoval from State	cem	etery, crem	atory or other p	1	2 / 0 /	Dom	~_ TT-1 1	Luclimed 1	
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57		23a. Part1. Enter the disease, or compti	cations that cause	d the death.	1			•			Approximate Interval Between	
DI CONTRACTOR		shock, or heart failure. List only or tmmediate Cause (Final	e cause on each I	ine.	-61	1 / 1	MPHON	14			Onset and Death	
Physician /Medical		disease or condition resulting in death)	Due to (or as	s a consequer	nce of):		FUFFU	271			10 yr	
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e exe lan a urial-1		resulting in death) Last	Due to (or as	s a consequer	nce of):							
ate ate	Ilcai		l				 					
as as	Mec	IF FEMALE:	3c. If yes, outcome									
death cer death cer e attendir	lan/	23b. Was decedent pregpant in the past 12 months?	1 Live birth	2 Fetal de	eath 3 🗆	Ectopic pregnar			23	 d. Date of deli Month 	very Day Year	
. 5 00	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	it time of deat	m 5	Other (specify)						
ords, F.C. requires that the den signed by the nould be detached		Part II. Other significant conditions cor	tributing to death	but not resulti	ing in the un	nderlying cause	given in Part I.	23e. Did to	bacco use	contribute to	the cause of death?	
S G	d by							1 🗆 Y	'es 2 🖾	No 3□Pr	obably 4 Unknown	
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	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 🗆 Inpat	iont 2 🗆 E	2/Outnation	t 3 DOA		ath <i>(Check only o</i> l Home 5 ☐ Resid		Other (Spe	nufu)	
	-	27. Manner of Death	28a. Date of Inj	ury 2	8b. Time of	28c. Ir		28d. Describe h			July)	
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al or al or al or al or al Dire	ert	4 Homicide	building, e	etc. (Specify)				City or Tow	ni, Jiaie)			
To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Salc	29a. Certifier 1 Certifying Phy	sician: To the bes	t of my knowle	edge, death	occurred at the	time, date and place	e, and due to the	cause(s) a	nd manner as	stated.	
he He n 24 he Fu	edical	(Check only 2 Medical Exami	ner: On the basis and manner s		n and/or my							
To the within 2 To the complet	Σ	29b. Signature and title of certifier	1	10	7/2	29c. Lice	ense number		29d. Date	signed (Monti	h, Day, Year)	
\sim		Dawara	carra	U)	11/2)	1	38398		2	120/2	2004	
1/2		30. Name and address of person who co	ompleted cause of	death (Item 2	120	Print)	DV DT	COCKE		111 2 1	110	
		31. Date filed (Month, Day, Year)	ULL IN	trar's Signatui	1380	or yo	NK ND,	WOCKE	= y > L	11-6	1,111	
St Regis	tate	FFR 2.5 2004	DZ. Hegis	uai s signatul	A see	20						

State of Maryland / Department of Health and Mental Hygiene 2004 05861 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 20 FEBRUARY 2004 LAWRENCE DAWSON **JARBOE** 8:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ST. MARY'S 40620 DELABROOKE ROAD MECHANICSVILLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1₩ 2□F **Director** 216-30-2565 1928 MARYLAND 76 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be positive at 1 ☐ Yes 2 No Director ST. MARY'S MECHANICSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 40620 DELABROOKE ROAD 20659 U. S. A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: Specify. 3½ Widowed 4 ☐ Divorced WHITE "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LUMBERMAN SAW MILL or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event sone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ELMER JARBOE ETOYLE DAWSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40790 DELABROOKE ROAD MECHANICSVILLE, MD 20659 DAVID D. JARBOE / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition FEBRUARY 20c. Location - City or Town, State ™ Burial 2 Cremation 3 Removal from State * 4 □Donation 5 □ Other (Specify) QUEEN OF PEACE CEMET. 23, 2004 MECHANICSVILLE, MD 22. Name and Address of Facility BRINSFIELD-ECHOLS FUNL.HME., P.A. 21. Signature of Funeral Service Licenses 1 Bailos long M00641 30195 THREE NOTCH RD. CHARLOTTE HALL MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ot 140 Zucer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ∴
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 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2**√**√√0 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation М 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Lead Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 2 Medicel Examine 29b. Signatury 29d. Date signed (Month, Day, Year) and title of certifie 29c. License number env · D 00506 FEBRUARY 20, 2004 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEON BERUBE, M. D. 28170 OLD VILLAGE ROAD MECHANICSVILLE, MARYLAND 20659 31. Date filed (Month, Day, Year) 2004 32. Registrar's Signature State oak Registrar

		1-	For State Registrar	State of	f Marylan	d / Depart	ment of h	Health and Death	Mental F	lygiene ,	2004	05862
/M	rsician ledical aminer	4a.	Decedent's Name (First, Middle, L DOVITA Frank Facility Name (If not institution, g Sing Hospital (ce Ja	CKSOT mbor) himore	1	b. City, Town, o	or Location of De	2. Date of Month Februar	ry 16	Year 2004 ounty of Death	3. Time of Death 3: 12 P M
Fune Direc	tor	2	Social Security Number 6. 15-74-1394 ual Residence of Decedent	Sex 1 □ M 21XF	7. Age (In yrs.		f Under 1 Year fonths Days	If Under 24 Hi Hours Mi		Birth Day, Year)	Birthp Cour	place (State or Foreign mitry)
.0036 hours after death with the Maryland tural', or Items 23s or 28s-f show	ector		a. State 10b. County	7	10c. Cit	y, Town or Locat	ion HIMOR 101. Zip Code	L		100 Citizo	on of What Cour	10d. Inside City Limits 1 Yes 2 □ No
ier death with t	Funeral Director	1	e. Street and Number 5810 Simmo Marital Status	NDS 12. Was Dec	AVC.		2	125 Hispanic Origin? Ian, Mexican, Pue	(Specify Yes or	1	. Race - Americ	can Indian,
-0036 hours after tural', or ite	þ.		1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, G Year or D	200 No ve Dates:	1 [Yes 20 No	Specify:	erto Filoan, etc.)	s	Black, White,	ACK
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S 1 ar	or other traumati	20	Novoard From a. Method of Disposition 1 Surial 2 □ Cremation 3	CC(M)		Place of Disposition compatible c	on (Name of ony or other pla	erle D	R. Apt	202 t	ation - City or To	MD 21215 own, State
Iltim	eny injury once.	21	. Signature of Funeral Service Lic	-0	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Sterne - 51	emeter lame and Addr 51 Ra	Ss of Facility V	20-04 aughni 1 Prko +	CGree	HMOFE ENE FUI MD 2	neral Sive
Physic /Medi		In	Ba. Part1. Enter the disease, or co shock, or heart failure. List on mediate Cause (Final sease or condition sulting in death)	a State	is Asti	hmaticu		ng, such as cardi	ac or respirator	y arrest,		Approximate Interval Between Onset and Death 2
760, te be executed to solve and the solve a	e burial-transit	Secar	equentially list conditions, any, leading to immediate use. Enter Underlying uses (Disease or injury at initiated events sulting in death) Last	b. — Twe to	(or as a consequence of as a consequence of as a consequence of a conseque	war.ou of):	* * * * * * * * * * * * * * * * * * * *					
Box e death cer he attendir	page 2 should be detached for use as the Completed by Physician/Medi		FEMALE: 8b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live	utcome of pregna birth 2 Feta nant at time of d	ildeath 3⊟Eo	stopic pregnanc ther (specify) _	у		23	d. Date of delive	ery Day Year
rds, P quires that an signed b	should be detact		nt II. Other significant conditions	contributing to	death but not res	ulting in the unde	erlying cause gr	ven in Part I.				he cause of death? pably 4 Munknown
Vital Records, sician: The law requires t	Complet	2	Diabetes Mellit	US						utopsy erformed?	prior to con death?	psy findings available impletion of cause of 2 No
Vital F ysician: Th	director.	25	i. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient	3□ DOA Ot	noc.	eath (Check on Home 5 R		☐Other (Specif	(v)
Division of or Attending Physical death.	rd Pr	27	Manner of Death 1 Natural 5 Pending 2 Accident investigat	ion	of Injury oth, Day Year)	28b. Time of Injury				oe how injury o		
Division or Attending I within 24 hours after death. To the Funeral Director: After	lled in by the funera Certification;		3 Suicide 6 Could not determine	ed 289. Plac	ling, etc. (Specil				City or	Town, State)		al Route Number,
• Hosp 24 hou	Medical	25	9a. Certifier 1 🔀 Certifying : (Check only 2 🗍 Medical Exone)	aminer: On the I	e best of my kno basis of examina nner stated.	owledge, death or ation and/or inves	courred at the ti stigation, in my	me, date and pla opinion, death oc	ce, and due to t curred at the tin	he cause(s) ar ne, date and p	nd manner as si lace, and due to	tated. o the cause(s)
To the within 2	Me Me	29	9b. Signature and title of certifier	· MD			29c. Licen	se number		29d. Date	signed (Month,	Day, Year) 2004
3		30	D. Signature and third of certifier Vishya D. Name and address of person what TANE VISHNUPA	o completed cau	ise of death (Iter	n 23a) (Type, Pri Belvede:	ne Aien	ue Balt	imere	Maryco	and 212	215
Re	State gistrar		Date filed (Month, Day, Year)	32.	Registrar's Signa		a40 -	**		V	1.00	-

DHMH 17 Rev 1/2001

France - Jackson

Patient Known as Davita

ORIGINAL

		1 _ State	State of Marylar	d / Department of He Certificate of D		ntal Hygiene	2004	05863
Physic	ian	Registrar 1. Decedent's Name (First, Middle, Last)		JONES	2.1	Date of Death Month Day	Year	3. Time of Death
/Medi Exami	cal ner	Ro32ER 4a. Facility Name (If not institution, give s 5. Social Security, Number 6. Sex		4b. City, Town, or L	ocation of Death	Date of Birth	County of Death A 9 Birthpl	ace (State or Foreign
Funeral Director			M 20 F 74	Yrs. Months Days	Hours Min.	(Month, Day, Year)	Count	(x) DE
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iter death with ritema 23a or	Funeral Director	535 Wildwax	2. Was Decedent Eyer in U Armed Forces? 1 20 Yes 2 \(\subseteq No	If Yes, specify Cuban,	Mexican, Puerto Rica	in, etc.)	4. Race - America Black, White, 6	
s within 72 hours after de pene. r than "natural, or item the Medical Exumination	Completed by I	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade)	Yes, Give Year or Dates: ation completed)	1 Yes 2 No 16a. Decedent's Usual Occupati (Give kind of work done du life. DO NOT use retired)	on ring most of working		d of Business/Ind	lustry
ld be filed withing the filed withing the filed within the ked other the ic event, the M	Be	Elementary Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Court Bai	8. Mother's Name (Fi	rst, Middle, Maiden S	Sumame)	
nd 2 shou with and M 27 is mar	To	19a, Informant's Name/Relationship (Type 19a) 20a. Method of Disposition	(WIFE)	19b. Mailing Address (Street and South Place of Disposition (Name of commetery, crematory of other place)	Date PKW	1. Kal-	Town, State, Zip	m026
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Physician /Medical		23a. Part1. Enter the disease, or complies shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the deale cause on each line. UROSE Due to (or as a consec	P515	such as cardiac or re	spiråtory arrest,		Approximate Interval Between Onset and Death
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ertificate be e ding physician e as the buris	Ical	IF FEMALE:	HYPER	TENTION				11
nat the death cert by the attendin etached for use	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 Fet 4 Pregnant at time of 6	al death 3 Ectopic pregnancy		2	3d. Date of delive Month	ry Day Year
quires tha	þ	Part II. Other significant conditions con - 13:24 TE1242	•			23e. Did tobacco us		e cause of death? ably 4 DUnknown
The law re ite has bee	Completed	- DECUBITUE - DEMENTIA				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autop prior to con death? 1 \(\subseteq \text{Yes} \)	osy findings available inpletion of cause of 2 No
or Attending Physician: The law requires tarter death. Diractor: After this certificate has been signe in by the funeral director, page 2 should be	To Be C	25. Was case referred to medical			26. Place of Death (C	heck only one)		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification;	27. Manner of Death 1 12 Natural 2 Accident 3 Suicide 4 Homicide 2 Natural 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At Inbuilding, etc. (Special	28b. Time of Injury M 28c. Injury a Work? M 1 □ Ye ome, farm, street, factory, office	at 28d. es 2 \(\bigcap \text{No} \)	Describe how injury Location (Street and City or Town, State)	occurred	
e Hospita 124 hours e Funeral	dical C	(Check only 2 Medical Examin	er: On the basis of examin	owledge, death occurred at the time ation and/or investigation, in my opin	nion, death occurred a	at the time, date and	place, and due to	the cause(s)
To th To th comp	Me	29b. Signature and title of certifier	Wars m	29c. License	23300	29d. Date	signed (Month, L	Day, Year)
"	8	30. Name and address of person who co	mpleted cause of death (Ite	29c. License D m 23a) (Type, Print) ろい ろうべく ちたしいん ature	DHIR.	PATEZ CON W. B	MD. ALTO S	T- 2122
Regis	tate	31. Date filed (Month, Day, Year)	32. Pagistrar's Sign	ature A	1			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05864 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** KEENAN MARY Ε. FEBRUARY 21 9:30 P M 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner GENESIS HAMMONDS LANE BROOKLYN PARK ANNE ARUNDEL CO. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Yeer) 7. Age (In vrs. last birthday) 214-12-8589 1 ☐ M 2 💢 F 93 Nov.19 1910 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 Yes 2 No Director Baltimore Md. n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1605 Webster Street 21230 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Yes 2 No white Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 0 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be F. Emerson Joseph L. Mav Anarino 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1605 Webster Street, Baltimore, Md. 21230 19a. Informant's Name/Relationship (Type, Print, Helen G. Wehberg (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Removal from State *4 □ Donation 5 □ Other (Specify) Glen Haven Memorial Pk.02/24/04 Glen Burnie, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility

McCully-Polyniak Funeral Home p.A 130 E. Fort ave. Baltimore, Md. 21230 Am Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imprediate Cause (Final disease or condition resulting in death) Lower rungrene IWK Due to (or as a consequence of): Atherosclerch Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 28 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number D394660 wrent the

31. Date filed (Month, Day, Year) State 2 5 2004 Registrar

Roberta Dur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

901 32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

within 24 hours after death To the Funeral Director:

completely filled in by

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked othar than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinat he inclified at any injury or other traumatic event, it a Medical Examinat himst be inclified at any injury or other traumatic event.

Physician

/Medical

Examiner

the attending physician and hed for use as the burial-transit

detached

been signed be should be determined by

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Physic	ian_	State of State of Hamman Amend Item #30 per Registrar 1. Decedent's Name (First, Middle, Last)	sozo z Ce	rtificate of Death	2. Date of Death Month	Day Year	3. Time of Death
/Med Exam	ical	4a. Fecility Name (If not institution, give street and not appear to a second s		4b. City, Town, or Location of Death	2	4c. County of Deal	
Funera Director		5. Social Security Number 6. Sex 1717-07-5520	7. Age (In yrs. last birthday, 90 Yrs.	Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y December	(ear) 9. Bin 29,1913	thplace (State or Foreign buntry) VA
anyland show	٦	Usual Residence of Decedant 10a. State 10b. County	10c. City, Town or L				10d. Inside City Limits 11€2Yes 2 □ No
death with the Maryland ms 23a or 28a-f show rmust be notified at	Director	10e. Street and Number	Perryva	10f. Zip Code	10g	J. Citizen of What Co	Χ.,
72 hours after death with the Marylan ratural; or items 28a or 28a-f show digal Exama at must be notified at	by Funeral	Armed F	2X No ive	21903 Was Decedent of Hispanic Origin? (Spril Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2√□ No Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race - Ame Black, Whit Specify: W	
within 72 hou ene. than "natura tha Wedical E	Completed	15. Decedent's Education (Specify only highest grade completed	16a. Dece (Give life.	edent's Usual Occupation a kind of work done during most of work DO NOT use retired) LMbUL	ing 16	Bb. Kind of Business/ Railroad	
be filed stat Hygi ed other	o Be Co	17. Father's Name (First, Middle, Last) Clay S. Lucas		18. Mother's Name	First, Middle, Ma Hutchen	iden Sumame)	
s 1 and 2 should ! Health and Men item 27 is marke other traumatic	ſ-	19a. Informant's Name/Relationship (Type, Print) Jean Singleton/Daughte		ing Address (Street and Number or Aura Reservoir Road Pe		1000	
Pages 1 ar nent of Hea ant: If item: ary or othan		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	20b. Place of Disp cemetery, cre		Date 20	c. Location - City or	Town, State
permit. Pages Department of Important: If it any Injury or conce.		21. Signature of Puneral Service Licenses	Tordie 2	2. Name and Address of Facility R. 111 S. QUEEN Stre	T. Foard	Funeral	Home. P.A.
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/Medical Examiner			(or as a consequence of):	Maybite On	elfall		
icate be executed physician and s the burial-transit	i Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence of):	CERTIFICATION APPROVE	D BA WEDION		
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Physician: this certific al director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/Outpatie	26. Place of Death ont 3 DOA Other: 4 Nursing Hor		ce 6 Other (Spec	cify)
fter fter		2 Accident investigation 2	of Injury ofth, Day Year) 28b. Time of Injury	Work?	28d. Describe how Fall from	injury occurred	9
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Plac buil	e of Injury - At home, farm, st ding, etc. <i>(Specify)</i>		28f. Location (Stree City or Town, S Perryvil		N Route Number,
te Hospi 24 hou te Funer	edical	(Check only 2 Medical Examiner: On the	e best of my knowledge, dea basis of examination and/or in nner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To th withir To th comp	W	29b. Signature and title of certifier	1 77 W WWW 100 100 100 100 100 100 100 100 1	29c. License number		Date signed (Month	
V	7	30. Name an address of person who completed car		Print) Greene St. Balto.		122/200	7
S Regis	tate trar		Registrar's Signature	pole	, FID Z1Z(Ji	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2.0.0

		1 - State Registrar Unpend Item 1. Decedent's Name (First, Middle, Item)	23a-b, Part 11,	27,Per MEÇE	artment of He 29,9416/04	geath	Reg.		
Physici		Zhixiu	,					20, 2004	3. Time of Deat 11:50 A
/Medic Examin		4a. Fecility Name (If not institution, g			4b. City, Town, or I		enruary	4c. County of Dee	
		Howard County Ge	neral Hospit	tal	Columb	ia		Howard	
Funeral Director		Social Security Number A Usual Residence of Decedent	Sex 7. Age 1	(In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days		Date of Birth (Month, Day, Ye EC 19, 1		thplace (State or Fore ountry) hina
dand ow		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Lim
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or 28g	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
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r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13. V		panic Origin? (Specify , Mexican, Puerto Rica	Yes or No-	14. Race - Am Black, Whi	erican Indian,
s I and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. The lattern 21s and Mental Hygiene. On them 23s or 28s-f show other traumatic avant, the Modical Examinating must be notified as	ğ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		I□Yes 2【XNo	Specify:	, 5.6.,		ninese
natu natu	Completed	15. Decedent's (Specify only highest g	Education trade completed)	16a, Deced (Give	lent's Usual Occupat kind of work done du	ion uring most of working	16b	. Kind of Business	/Industry
than the	d m	Elementary/Secondary (0-12)	College (1-4or 5+) [5 1	
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should nd Men marke umatic	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street an	nd Number or Rural Ro			Zin Code)
nd 2 alth a 27 Is r trau		Fuzheng Pan/Hu	isband	Apt.	3-17-50-10	0 11 Colle	ge Road	Wuhan, F	IUBEI 4300
of Hei		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other place)	Date	20c.	Location - City or	Town, State
Page nent nt: If rry or		1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State			nc. 2/24/	∩/ı B	altimor	e. MD
permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic avant, the Magnes.		21. Signature of Funeral Service Lie Edward A	regorchik	22 C	Name and Address	of Facility Society Prick Roa	of MD	, Inc.	WD 0400
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Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Peritoniti	S					Interval Between Onset and Deat
Examiner	-	Sequentially list conditions,	b. AGENOTE	Duodenal): UI	cer Associat	ed With Antr	al Brunne	r's Gland	
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requires mai me deam certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
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cate has b page 2 sl	E		7111				autopsy performed?	prior to d	completion of cause
certifica	Be C	25. Was case referred to medical				26. Place of Death (Ch	Yes 2 1	Vo 1 1 ALYes	2 No
S 0	To	examiner? 1X Yes 2 ☐ No	Hospital: 1 Inpatient	2 X ER/Outpatient			1	6 □Oher (Spec	cifv)
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within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ▼Medical Exa	hysicien: To the best of r miner: On the basis of ex and man fer state	(amination and/or invi	occurred at the time, estigation, in my opin	date and place, and coon, death occurred at	lue to the cause the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
To Lo	2	29b. Signature and title of certifier	1 //		29c. License n	number	29d. D	ate signed (Month	, Day, Year)
1	-		1 1/ N		0.	C.M.E.	Feb	ruary 21,	2004
Corr				~/					
Carl		30. Name and address of person who	completed cause of deat	th (Item 23a) (Type, P		reet, Balt			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) LARRICK Month **Physician** ,ecil -ep 2:00 FM 2004 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE VA MediCAL Clater timore NIA If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Dey, Year)
Apr. 4, 1919 9. Birthplace (State or Foreign Country) West Virginia 5. Sociel Security Number 7. Age (In yrs. last birthday) Funeral XXM 2□ F 84 Director 202-12-5588 Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. Its Medical Experiments 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Funeral Director Star Tannery Frederick 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1626 South Pifer Road 22654 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 □XYes 2 □ No 194. If Yes, Give Year or Dates: 194. 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1941 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2√∑No Specify: Specify: White Completed by 1945 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Mechanic Automobiles Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick C. Larrick Altha Oates 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Verda Bradley Larrick - Wife 1626 S. Pifer Rd., Star Tannery, VA 22654 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/15/04 Kirby, WV 4 ☐ Donetion 5 ☐ Other (Specify) Hotts Chapel Cemetery 21. Signature of Funeral Service Ligansee 22. Name and Address of Facility
Giffin Funeral Home P.O. Box 100 Capon Bridge, WV 26711 23a. P. rt1 Enter the disers. A complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical MIRNIN INSWERCENCY To lawre LEG Z DAYS Examiner Due to (or as a consequence of) Physician/Medical Examiner ZO YEARS DUSEASE PARIPHALK Mount or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) P.O. Box 68760, Due to (or as a consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Probably 4 Unknown ANTERUN DUSCASE occusive Division of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? sevor reme FALLURE 1 □ Yes ANo 20 No 1 Yes 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospitel: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes No : After this funeral 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Naturel 2 Accident 5 Pending n 24 hours efter deeth.

• Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) within 2 tle of certifier 29b. Signature end 29d. Date signed (Month, Dey, Year) SHRELLER RESIDENT, who completed ceuse of death (Item 23e) (Type, Print) end eddress of p 10 N GREENE STROET BALTIMORE MD 21201 4220 31. Dete filed (Month, Day, Year) 32. Registrer's Simature State FEB 25 Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Mary		artment of H			ene 200L	05868
-	Physic /Medi		1. Decedent's Name (First, Middle, Las	Lichlite.				2. Date of Death Month		
	Examir Funeral	ner	5. Sociel Security Number 6. Se	eneral /-	Joseph Jul yrs. last birthday)	4b. City, Town, or If Under 1 Year Months Days	Location of Death If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) June 30,	4c. County of Dec	ath (rthplace (State or Foreign Country) Maryland
0.	Director		Usual Residence of Decedent 10a. State 10b. County	□ M 20XF	Yrs.		110013	June 30,	1928	
	the Maryla 28a-f shor	ector		oward	o. ony, fown of co	E	llicott City			10d. Inside City Limits
	s 23a or 3	Funeral Director	8720 Ridge Road			10f. Zip Code	21043		g. Citizen of What C U	
9800	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show to Madical Examinar must be notified at	d by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces 1 Yes 2 No If Yes, Give Year or Dates:	11	Vas Decedent of Hi Yes, specify Cuba □ Yes 2 No	Ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	be filed within 72 ho ital Hygiene. id other than "natui event, Ira Madical.	Completed by	15. Decedent's Ed (Specify only highest grades) Elementary/Segntino(0112)			lent's Usual Occupa kind of work done o OO NOT use retired NU I		ting 16	Sb. Kind of Business Convele	s/Industry scent centers
/land	should be filed nd Mental Hygid marked other umatic event, II	To Be (17. Father's Name (First, Middle, Last) Gerard Al	ndrew Myers			18. Mother's Nam	e (First, Middle, Ma Winifred Be	iden Sumame) ssie Weetenk	camp
	nd 2 she lith and 27 Is m		19a. Informant's Name/Relationship (7 Mr. Theresa Davis	ype, Print) Daughter	19b. Mailin 2	g Address <i>(Street a</i> 94 Hahn Roa	and Number or Run ad Westminst	al Route Number, C ter, Maryland	City or Town, State, 21157	Zip Code)
Baltimore,	Pages 1 arment of Hea ant: If itam ury or oths		20a. Method of Disposition 1 Surial 2 Cremation 3 Donation 5 Other (Specify	Removal from State	0b. Place of Dispos cemetery, crem Good Sh	sition (Name of natory or other place nepherd Cem	9) 1 00	Date 20 /27/2004	c. Location - City or Ellicott C	Town, State ity, Maryland
Balt	permit. Page Department (Important: If any injury or		21. Six dure of Fyneral Service Line	L mass.	3 5	Name astacker 3871 C	นท์ยิชิที่Home old Columbia	e, P.A. Pike Ellicott (City, MD 2104	3
Æ,	Physician /Medical Examiner	ner	23a Part1. Enter the disease, or companies shock, or heart failure. List only of firmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, isading to immediate cause.	a. Due to (or as a co	Many 1	er the mode of dying		or respiratory arrest	i,	Approximate Interval Between Onset and Death
,820,	cate be executed physician and the burial-transit	dical Examiner	il any, Isaamig to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cord	nsequence of):					
.O. Box 6	es that the dea h certific igned by the at ending p be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P	w requires that been signed should be del		Part II. Other significant conditions co	ntributing to death but no	t resulting in the un	derlying cause give	n in Part I.		_	o the cause of death?
Vital Records,	The lavate has	Completed by			0'			24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
of Vit	Physicien: rthis certificaral director,	To Be	1 163 2 140		2 ER/Outpatient		r: 4 Nursing Ho	n (Check only one) me 5 ☐ Residenc		cify)
Division	To the Hospital or Attending Physicien: To the Funeral Director After this certific Completely filled in by the funeral director.	Certification:	27. Manner of Death L Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Yea 28e. Place of Injury	At home, farm, stre		? ′es 2 □ No	28d. Describe how 28f. Location (Stree	at and Number or Ru	ural Route Number,
ā	ospital or hours afte uneral Dir y filled in		29a. Certifier 1 Certifying Phy	building, etc. (S)	knowledge, death	occurred at the time	e, date and place,	City or Town, S	re(s) and manner as	s stated.
	ro the He	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	ner: On the basis of examined manner stated.	mination and/or inve	estigation, in my op 29c. License	inion, death occurr	ed at the time, date	and place, and due Date signed (Monti	to the cause(s)
)	2		· fre			D461	20	1	6, 23,	
	0		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type, P	rint)	PKwa	(slowh	10 MO	21224
2	Sta Registr		31. Date filed (Month, Day, Year)	2 5 2004	nature	South			,	

	_		For State Registrar	State of Maryla		artment of Heartificate of De	ath	Reg	ene 2004	05869
	Physici		1. Decedent's Name (First, Middle, Last	leod			1	2. Date of Death Month	Day Year	3. Time of Death 4.43 PM
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)	1	4b. City, Town, or Loc			4c. County of Death	
			01710317	ryland Hose	a tal	Baltimo		yland	N/A	(D)
	Funeral Director		5. Social Security Number 6. Se 114-92-9706	X M 2 \square F 45	. last birthday) Yrs.		Under 24 Hrs. ours Min.	B. Date of Birth Month, Pay, 3	(ear) 9. Birthp Court Ba.1	lace (State or Foreign try) timore, Md
140	ס		Usual Residence of Decedent	140-0	-					
	show	'n	10a. State 10b. County	j	ity, Town or Lo				1	0d. Inside City Limits 17 Yes 2 □ No
	the N 289-f	rect	Md. N/A 10e. Street and Number		Balti	101 Code		100	g. Citizen of What Cour	ntry?
	h with 23a or	ai Di	2020 Featherb	ed Lane.		21207		υ	ISA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23s or 28e-f show eny injury or other traumatic event, It a Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:		Was Decedent of Hispar f Yes, specify Cuban, M 1 ☐ Yes 2 XNo Si	nic Origin? (Spec lexican, Puerto R pecify:	ify Yes or No- ican, etc.)	14. Rece - Americ Black, White, Specify: B1	etc.
21215-0036	72 ho natur	Completed	15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occupation kind of work done durin	n ng most of working	7	b. Kind of Business/Inc	dustry
121	within ene. than	idu	Elementary/Secondary (0-12)	College (1-4or 5+)		ability			Disabili ⁻	+ 1 77
d 2	Hygie other	Be Co	17. Father's Name (First, Middle, Last)		DIS		Mother's Name (c y
/lan	should be nd Mental rmarkad o	To B	James Mcle	od			Mary N	cleod		
Maryland	2 sho and 1 is me	·	19a. Informant's Name/Relationship (T			ng Address (Street and i				
	1 and Health em 27		Mary Mcleod M 20a. Method of Disposition		Place of Dispo	O Feather stition (Name of	bed Lar		imore, Md Oc. Location - City or To	
Baltimore,	permit. Pages Department of Importent: If it eny injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licenses)	rbutu	matory or other place) S Mem.Pk.	2-27-	-04 A	rbutus,Mo	
Ba	Depa impo eny i		Lloyd M. Est	ep_	E.	Name and Address of step Brot 300 Eutaw	hers Fu	neral Baltim	Ser, P.A.	21217
	7.12		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the dea						Approximate Interval Between
}	Physician		Immediate Cause (Final disease or condition		PSI	2				Onset and Death
в	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
	\$ \$ 3.7	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of):					
	ocuted .nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.						
1760,	icate be executed physician and s the burial-transit	cai	resulting in Geattly East	Due to (or as a conse	iquence or):					
.O. Box 68	death certif e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of preging 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
<u> </u>	res that the de igned by the a be detached f	by Ph	Part II. Dther significent conditions co	entributing to death but not re	sulting in the u	nderlying cause given in	Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
rds	v requires been sign should be	ed b						1 ☐ Yes	2 □ No 3 □ Prob	ably 4 Unknown
Vital Records,	The lay	Completed						24a. Was an autopsy performe 1 ☐ Yes 26	prior to condeath?	psy findings available impletion of cause of 2D(No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			. Place of Death			
Division of	ding J. After fune	tion: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Da e of Injury (Month, Day Year)	28b. Time o Injury	28c. Injury at Work?		a 5 Hesiden	ce 6 Other (Specify injury occurred	/)
Divis	i i i i	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, sti cify)	reat, factory, office	28	If. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	ledicai (vsician: To the best of my kr iner: On the basis of examin and manner stated.						
•	To t To t com	W	29b. Signature and title of certifier	Les, dert Phy			267	T.	Date signed (Month,	, 2004
	V		30. Name and address of person who country Roser H						c, MO 2	1201
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	L A	Card a				
DH	IMH 17 Rev 1/2		FEB 2 5 20	U4 Fee	AT AS					
					ORIGIN	AL				

			1 - For Stete Registrar	State	of Maryland	Depa Ce	artment of H	ealth and I Death	Mental Hygi	ene 20	04 05	5870
	Physic /Medi		1. Decedent's Name (First, Middle, L James S. Moore						2. Date of Death Month	Day Y	ear	of Death
1	Examir		4a. Fecility Name (If not institution, g. Doctor s Hospit		imber)	***	4b. City, Town, or Lanham	Location of Death		4c. County of		
	Funeral Director		239-12-3315	Sex 1XIM 2□F	7. Age (In yrs. last 82	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 17,	^{Year)} 1921 1	Birthplace (State Country) North Ca	_
	r 28a-f show	irector	Usual Residence of Decedent	George'	10c. City, To		stville		10	g. Citizen of Wha		City Limits
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be muitined at ODGE.	by Funeral Director	3513 Pinevale A 11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced		2 X]No ve		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	20747 spanic Origin? (Sin, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	Black, 1	A American Indian, White, etc. White	-
121215-0036	iled within 72 ho tygisne. her than "natur nt. Itte Wedical	Completed	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12) 12	rade completed) College (4		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of wor }	king	Sb. Kind of Busin		
Maryland	id be fi ental H ked ot ic ever	To Be	William Sheperd	,					ne (First, Middle, Ma bank Hinr	,		
lary	and Mand Me mark	-	19a. Informant's Name/Relationship				ng Address (Street a	nd Number or Ru	ral Route Number,	City or Town, Sta		
	l and 2 lealth m 27 I her tre		Audrey Moore/spo	use					Forestvil			
Baltimore,	Pages timent of H tant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 i 4 ☒ Donation 5 ☐ Other (Spec	ify)	State ceme	itery, cren	sition (Name of natory or other place	9)		oc. Location - Cit		
Bai	Departing Departing Support Su		21. Signature of Funeral Spice Sico	11111	240	100	TCTHOIC,	TID 2120			e Street	-
>	Physician /Medical		23a. Part 1 Enter the disease, or cor shock, or heart failure. List only Immediee Cause (Final disease or condition resulting in death)	a. —	caused the death. Deach line.		er the mode of dying			t,	Approxim Interval B Onset an	letween d Death
,8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to uninvolute cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c.	(or as a consequence							
P.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1☐Live t	tcome of pregnancy birth 2 Fetel dea nant at time of death own		Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day	Year
	w requires that been signed b should be deta	ρ	Part II. Other significant conditions	contributing to d	eath but not resulting			n in Part I.	4		te to the cause of	
Division of Vital Records,	sician: The law re certificate has be irector, page 2 sho	Completed							24a. Was an autopsy performe	d? prior	e autopsy finding to completion of h? Yes 2 \sum No	s available cause of
Zii:	sician certifi rector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	/		3 DOA Othe		h (Check only one)			
on of	ing Phy After this uneral d	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mon	Mipatient 2 ☐ ER/0 of Injury 28b th, Day Year)	Dutpation Time of Injury	28c. Injury Work	4 Nursing Ho	me 5 Residence 28d. Describe how		Specify)	
Divis	or Al	Certification:	3 Suicide 6 Could not t 4 Homicide determined	200. Place	of Injury - At home, ng, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	et and Number of State)	r Rural Route Nu	m <i>ber</i> ,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the b	best of my knowled asis of examination a ner stated.	ge, death and/or inv	occurred at the time estigation, in my opi	e, date and place, inion, death occur	and due to the caused at the time, date	se(s) and manne and place, and	r as stated. due to the cause	(s)
)	To t To t	×	29b. Signature and title of certifier		no		29c. License		29d	Date signed (M	fonth, Day, Year)	
			30. Name and address of person who カット け・ とっしょ	stras	- mo 74	i) (Type, i	Print)	ve Pl.	1002	en hem	mo 2	0050
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 5 20	04	egistrar's Signature	Sa						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Deeth - Month **Physician** February George Т. 30 AM Murray /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daat 4c. County of De Examiner Hospita Glen Bud ar If Undar 24 Hrs. If Under 1 Yaar 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) Funeral 1918 Months Hours 1X M 2□ F 705-12-7496 85 Maryland Director Usual Basidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 XNo Director MD Anne Arundel Odenton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1390 Odenton Road 21113 USA Funeral Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forces? 14. Race - Amarican Indian, 11 Marital Status Black, White, etc. 1 KD Yas 2 □ No If Yas, Giva WWII Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 🗓 Xio Specify: White Spacify: Š 3 Widowad 4 □ Divorced Completed 16a. Dacedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Congressional Aid U.S. House of Rep. Important: If Item 27 is marked other any injury or other traumatic event. 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be Pages 1 end 2 should be nent of Health end Mental George T. Murray, Sr. Marie Kenney 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Code) Kevin Murray (Son) 1390 Odenton Road, Odenton, MD 21113 20b. Place of Disposition (Nama of cematery, crametory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 2/28 Data tXXBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata **Depertment** Millersville, MD 4 ☐ Donation 5 ☐ Othar (Specify) Our Lady of the Fields 2004 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Kidgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the diseast or complications that caused the teath. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Daath **Physician** (erebral Vascular Accident Immediate Cause (Final disaasa or condition rasulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequantially list conditions, if eny, leading to immadiata ceuse. Entar Undarlying Cause (Diseasa or injury Dua to (or as a consaquance of): Division of Vital Records, P.O. Box 68760, Dua to (or as e consequence of) resulting in daath) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to tha cause of death? 3 ☐ Probably 4.E(Unknown 1 ☐ Yes 2 ☐ No sete hes been signed page 2 should be de Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□Yes 22No 1 ☐ Yes 2 ☑ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Ø Inpatient 2 □ ER/Outpatient 3 □ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Spacify) 1 Yes 2 No Medical Certification: To 27. Mannar of Deeth 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Metural 1 ☐ Yes 2 ☐ No To the Hospital or Attendion within 24 hours efter death. To the Funeral Director: A 2 ☐ Accidant 6 Could not be detarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 29a. Cartifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifian 29d. Date signed (Month, Day, Year) Nysieran 30. Name and eddress of person who completed causa of death (Itam 23e) (Type, Print) H05 0 Dital 31. Data filed (Month, Day, Year) 62. Registrar's Signatura State FEB 2 5 2004 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2004 05872 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Year Margaret McCubbin FEBRUARY 23, 2004 04104 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death #B ALL I MO RETURN OF THE STATE Examiner ST AGNES HEALTH LARE 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) **Funeral** 1□M 2X1F 107 218-66-1547 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. a 23a or 28e-f show 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5535 Channing Road 21229 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or itame 11. Marital Status other traumatic event, the Madical Exeminer of Black, White, etc. filed within 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√2 No Be Completed by Specify: 3 ₩ Widowed 4 Divorced 'naturel' White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 ie marked othe any liury or other traumatic event ODEs. 18. Mother's Name (First, Middle, Maiden Surname) Wicker Burl Elizabeth Donaldson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Anna Taylor - daughter 499 Hills Court, Westminster, Maryland 21158 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Mt. Olivet Cemetery 2/26/2004 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebro Vascular Acci Physician /Medical Examiner MPRY ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tyes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 M No 1 🗌 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this s 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred of or Attending Patter death. After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitel or within 24 hours after To the Funeral Die 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 23, 2004 b 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 900 Sti-Beaman Cator Avt Baltimure mp -maruel 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FFB 2 5 2004 Registrar

MARGARE

		1	For Amend Item #4b-c per phy did to Gozga 2/2	of Health and Mental I 5/04 tas of Death	Hygiene 2004	05873
Ph	ysicia		1. Decedent's Name (First, Middle, Last) Charles Farle, Mace	2. Date of Month	Day Year	3. Time of Death 10:45AM M
	Medica amine		0 0 10 1 1000	wn, or Location of Death Perry	4c. County of Death	
Fur	eral		Months Di	rear If Under 24 Hrs. 8. Date of ays Hours Min. (Month,	Dav. Year) Cour	Baltimore oface (State or Foreign otry)
Dire ਹੁ	ctor	-	Usual Residence of Decedent	11/12		• Amaryland
the Marylan	led at		MD Baltimore 10c. City, Town or Location Perry Hall			1 ☐ Yes 2 No
with the	De noti	by Funeral Director	10e. Street and Number 10f. Zip Co		10g. Citizen of What Cour	ntry?
death w	ermust	nerai	4525 E. Joppa Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent If Yes, specify in If Yes	I Ζδ t of Hispanic Origin? (Specify Yes or Cuban, Mexican, Puerto Rican, etc.)	U.S.A. 14. Race - Americ Black, White,	
036 burs after dea	Examin	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No ff Yes, Give 7 ear or Dates: ₩₩ II		Specify: Whi	
Maryland 21215-0036 4 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 77 is marked other than "natural", or Itams 23e or 28e-f show	other traumatic event, the Madical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+)	lone during most of working	16b. Kind of Business/In	dustry
ore, Maryland 212 st and 2 should be filed with Mealth and Mental Hygiene Men 27 is marked other than	nt, the		12 2 Electrici 17. Father's Name (First, Middle, Last)	ian 18. Mother's Name (First, Mid	Mace Elec	tric
arylanc should be fund Mental Is	atic eve	To Be	Howell Mace	Alice Anders		
Mary nd 2 sho lith and	r traum			treet and Number or Rural Route Nu opa Road - Perry		
MOTE, Pages 1 ar			20a. Method of Disposition 1 'Q'Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other	of Date	20c. Location - City or To	
Baltimore, permit. Pages 1 at Department of Hea	injury B.	1	21. Signature of Funeral Service Licensee 22. Name and A	n Cem. 02/23/2004	Baltimore, Funeral Home	Maryland
	any Spoot		7401 Bel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of	air Rd. Baltimor	e, Md. 21236	Approximate
Physi	cian	1	shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
/Med Exam			I was	Tuve		~ y yeers
Pe	ısıt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
8760, ate be executed hysician and	burial-transit	Exar	that initiated events consequence of			
68760, tificate be expensed	the l	edicai	d			
Box (eath certif	for use	by Physician/Med	## FEMALE: 23b. Was decedent pregnant in the past 12 prouths? 4 Pregnant at time of death 5 Other (specific		23d. Date of delive Month	ery Day Year
P.O.	detached for	Physi	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying caus		Did tobacco use contribute to the	ne cause of death?
Records, P.O. Box 6i The law requires that the death certific sie has been stoned by the attending p			-alt II, Otto significant containing continuing to death but not resulting in the didentying caus-		☐ Yes 2☐No 3☐ Prob	
Vital Records, sician: The law requires to certificate has been stone	page 2 sho	Completed		a	erformed2 death?	psy findings available mpletion of cause of
	rector, pa	Be Co	25. Was case referred to medical examiner?	1 ☐ Ye	es 2 (No) 1 Yes	2 □ No
Phy Phy	5	ှု ရ	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c.		ence 6 Other (Specificial Control of the following occurred)	y)
Division of atter death. Director: After Director: After	the fun	icatio	2 Accident investigation M	1 ☐ Yes 2 ☐ No	on (Street and Number or Rura	J Route Number
Divi	ed in by	Certification:	3 ☐ Suicide 4 ☐ Homicide See. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	City or	Town, State)	n node names,
Divisit Divisit Tuthe Hospital or Attent within 24 hours after death	completely filled in by the	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the basis of examination and/or investigation, in and manner stated.	ne time, date and place, and due to my opinion, death occurred at the tir	the cause(s) and manner as si me, date and place, and due to	tated. the cause(s)
To the	ccmp	×	200. Olgridio and this or solution	D-34931	29d. Date signed (Month,	Day, Year)
(X			30. Name and ado ess of person who completed cause of death (frem 3al 1 ype, Print)	1,	21200	1
ט	Stat	6	31. Date filed Merry Day, Kearl Das S2. Registrar's Signature	1d 21236		
R	eqistra		FED 6 3 2004 Roma 11. Specific	•		

Chas EARLE

			For State Registrar	State of Maryland / Depa Cer	artment of Health and M <i>rtificate of Death</i>	fental Hygie Reg	ne 2004	05874
			1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al	DUANYÉ DWI	GHT MOORE,	TR	FEBRUARY	17,2004	1235 AM
30	Examin		4a. Facility Name (If not institution, give st	reet and number)	46. City, Town, or Education of Death		4c. County of Death	
			MERCY MEDICAL 5. Social Security Number 6. Sgx		BALTIMORE If Under 1 Year If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
Н	Funeral Director		Infant	M 2 ☐ F 7. Age (In yrs. last birthday) Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y FEBRUAR.	ear) 4 Cou	intry) MD
		ļ	Usual Residence of Decedent					10d. Inside City Limits
	arylan	_	10a. State 10b. County	RAIL:				1 Yes 2 No
	the M	ecto	N/A 10e. Street and Number	BAItin	101 E	100	. Citizen of What Cou	intry?
	with with	ă		ASON COURT	21231		U.S.	4
	me 2:	by Funeral Director		2. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White	
ဖွ	or Ita	Fui	1 Never Married 2 Married	1 Tyes 2 No	1 ☐ Yes 2 No Specify:	i tiodii, oto.)	Specify: 2 1	Ar 4
60	ural',		3 Widowed 4 Divorced	Year or Dates:	dent's Usual Occupation	16	b. Kind of Business/li	7 C //
7	in 72	Completed	15. Decedent's Educi (Specify only highest grade	completed) (Give life.	kind of work done during most of work DO NOT use retired)		b. Rind of Edulinosan	
212	with jiene r thar	mo	Elementary/Secondary (0-12) 0 Infant	College (1-4or 5+)	N/A Infant		N/A	Infant
b	al Hyg	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Ma	. 1 .	-
<u>yla</u>	Menta Menta arked	To		H+ MOORE	DER ITE	7 71	aw Itins	S - (-)
Maryland 21215-0036	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Typ	9, Print) 196. Mailie	ng Address (Street and Number or Rur	al Houte Number, C	RA14	ma 2/23/
e,	1 and Healti em 2		20a. Method of Disposition	20b. Place of Dispo	osition (Name of	Date 20	c. Location - City or T	Town, State
IOI	ages ant of nt: If it		1 Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)	emoval from State Woodlawn	matory or other place) Cemetery 02/2	3/2004 W	oodlawn, M	Saryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural", or Itame 23s or 28s-t show importants if item 27 is marked other than "natural", or Itame 23s or 28s-t show any injury or other traumatic event, in Medical Examinar must be notified at ODGs.		21. Signature of Funeral Service License	4 0	Name and Address of Facility Sterling-Ashton-Sc 736 Edmondson Ave.	hwab Fune	eral Home,	Inc.
	45244		23a, Part1. Enter the disease, or complic	ations that caused the death. Do not en				Approximate Interval Between
	Physician		shock, or heart failure. List only one Immediate Cause (Final	e cause on each line. PRETERM LABE	nQ			Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):				
9	Examiner		Sequentially list conditions, b.	PREMATURE RUP	TURE OF MEME	BRANES_		
	sit ad	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	sician and burial-transit	Examiner	that initiated events c. resulting in death) Last	CHORIO AMNI DT Due to (or as a consequence of):	13			
8760,	ate be ex hysician the buria	dicai E	L _d					
9	uficate g phys as the	edic						
Box	death certificate be executed e attending physician and nd for use as the burial-transit	an/M	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3[□Ectopic pregnancy		23d. Date of delin	very Day Year
Ю. В		Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of death 5[Other (specify)		(MOITH)	Day 10a
Δ.	t th by		Part II. Other significant conditions con	tributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Vital Records,	es Be	d by			, , ,	1 ☐ Yes	2 No 3 □ Pro	obably 4 🗆 Unknown
COL	> .Q (2)	Completed				24a. Was an	24b. Were au	topsy findings available
Re	0 5 0	отр				autopsy performe		ompletion of cause of
ital	ian: The rtificate stor, pag	0	25. Was case referred to medical		26. Place of Dea	th (Check only one)	7.0	
of V	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	ospital: 1 npatient 2 ER/Outpatie	The state of the s		ce 6 □Other (Spec	uty)
o u	ding Plan.	iuo	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	injury occurred	
Division	Attending ir death. ector: Attei by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, st		28f. Location (Stre	et and Number or Ru	ral Route Number,
Ω	al or A s after Il Direct	Certification:	4 Homicide determined	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town,	State)	
	To the Hospital or Attend within 24 hours after death To the Funaral Director: completely filled in by the f	edical C		sician: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.				
	Vithin 2 To the comple	Me	29b. Signature and title of certifier	11/1	29c. License number		I. Date signed (Month	
)			reja /	roundet	10 DOG4188	54 Fe	broary 17	1,2004
			30. Name and address of person who co	mpleted cause of death (Item 23a) (Type	, Print) Nancy Bro	Wn-Hoi	H, MO	
			31. Date filed (Month, Day, Year)	, 32. Registrar's Signatyre	,			
	Sta Regist	ate rar	51. Date filed (Month, Day, Year)	32. Hogistrar's Signature	ponke			

State of Maryland / Department of Health and Mental Hygiene 2004 05875 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death
430 pm 2. Date of Death Day Month **Physician** Vear Ma 22210 leanos February 13 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brooke Grove Rehab and Mussing Sandy Sping Mantgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthptace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 015-12-1539 Director 87 Feb 15. 1916 Revere, MA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐XNo Completed by Funeral Director Norfolk Milton the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 456 Central Ave. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No tf Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied w
Department of Health and Mental Hygien
Importent: if Item 27 is marked other th.
any injury or other traumatic event, the 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willard Legg ၉ Margaret McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John T. Nazzaro - Son 19113 Holberton Lane., Brookville, MD 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Milton Cemetery 2-17-04 Milton, MA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Alfred D. Thomas Funeral Home 326 Granite Ave., Milton, MA ennis Mmen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final **Physician** Carebrovascular disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Dettension Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and attending physicien and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 ØUnknown peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 2 □ No 1 ☐ Yes 2. ☑ No 1 TYes or Attending Physicien: director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural s after decreted by a street of the section of the 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel I To the Hospitel pellij 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Chitosprays, M.A. 039793 February 14,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Christoplas J. Mays, Mod. 18111 Prince Philip DR. #328 Olney, MD 20832 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05876 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician Year 2004 /Medical 4c. County of Death Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner vindale NA Home Kaltin Date of Birth (Month, Day, 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Year) 216-12-789 Hours Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Items 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 Married 1 Never Married by f Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Ie marked other than." Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant' Name/Relationship (Type, Print) 19b. Mailing Address (Str. et and Number or Rural Routs Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place 1. Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 15 Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pitco ta 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner Tary leading to impact cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be exect the attending physician ar hed for use as the burial-Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 Yes 2 No 9☐ Unknown 9 Unknown à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed PVD 1 Yes 2 No 1 Yes 200 No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Division After 1 Natural 5 Pending Injury To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) l in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai npletely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvede live Baltim 31. Date filed 7 2 00. 5 2004 32 Registrar's Signature State Registrar

			1 - For State Registrar	State of Marylan	d / Depart <i>Certi</i>	ment of H	lealth and Death		Reg. No.	2004	05877
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	Tincey				2. Date of Deamonth February	20 20	Year 2004	3. Time of Death //: 40 PM
_	Examir Funeral	ier	4a. Facility Name (If not institution, give s Sina; Hospital 6. Sex		ast birthday)	b. City, Town, or Balls 1 Under 1 Year 1 Onths Days	Location of De	rs. 8. Date of Birt	h	9. Birthp	place (State or Foreign
	Director	or	Usual Residence of Decedent 10a. State 10b. County	1 02	, Town or Local	ion		104.09	-41	1	Od. Inside City Limits 1 XYes 2 □ No
	ath with the N 23a or 28a-f	Funeral Director	10e. Street and Number 3501 LUCILLE A	renue	Our	10f. Zip Code	215			en of What Cour	/\
9036	within 72 hours atter death with the Maryland ene. Han "natural", or llame 23a or 28a-f ahow I a Medical Evanii ar maal be notified al	b	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divolced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	II Y	s Decedent of H es, specify Cuba Yes 22 No	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		4. Race - Americ Black, White, Specify: BL	
21215-0036	d within 72 h giene. er than "natu i y e Medical	Completed	15. Decedent's Educ (Specify only highest grade Ejementary/Secondary (0-12)		(Give kırı	t's Usual Occupi d of work done of NOT use retired	during most of w	vorking	16b. Kind	d of Business/In	dustry ARE
חם	should be filed within of Mental Hygiene	To Be (17. Father's Name (First, Middle, Last) ERNEST KEII 19a. Informant's Name/Relationship (Ty	e, Print)	19b. Mailing ,	Address (Street	ARM	ame (First, Middle,	bino	Hetar	(Cpde)
ore,	permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens Department of Health and Mental Hygiens Department or I terme 23a or 28a-1 ahow montain; I terme 23a or 28a-1 ahow any injury or other traumatic avant, II a Medical Evarul at minal be notified at ances.		20a. Method of Disposition 10 Burial 2 Cremation 3 R		lace of Disposition		Ave	Patimo Date 25 M	20c. Loc.	ation - City or To	21215 own, State
Baltimore,	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service License	M	9 FCK 22. N 50	Batte	ss of facility (Lughn C. Pike, Pa	tim	efurera cre, M	1 Service D 21229
	nysician /Medical	70	23a. Part1. Enter the diselase, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the death a cause on each line. Arrh + Due to (or as a consequence)	hmia	he mode of dyin	g, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
7	cate be executed x x physician and physician and it the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	Failus	`c					
Box 6	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3 Ec	topic pregnancy ther (specify)			23	d. Date of delive	ery Day Year
S, D	sign sign d be	by	Part II. Other significant conditions con Hyperte	tributing to death but not resu Sion Mellifus	ulting in the unde	rlying cause give	en in Part I.				ne cause of death? ably 4 Munknown
l Rec	The law ate has b page 2 si	Completed		Mellitus				24a. Was autop perfor 1 🗆 Yes	med? 2 X No	24b. Were auto prior to cor death? 1 \(\sum \) Yes	psy findings available mpletion of cause of 2 No
	Phys rthis rat dii	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗷 No 27. Manner of Death	28a, Date of Injury	ER/Outpatient	3 DOA Othe	er: 4 🗆 Nursing	eath (Check only of Home 5 Resid	ence 6		1)
Division	To the Hospitel or Attanding Pri within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral	Certification:	1 SNatural 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation determined	(Month, Day Year) 28e. Place of Injury - At he building, etc. (Specify	Injury nme, farm, street	M 1 🗆	k? Yes 2 □ No	28f. Location (S City or Tow		Number or Rura	l Route Number,
	n 24 hours n 24 hours ne Funere sletely filler	edical C		ician: To the best of my knower: On the basis of examinal and manner stated.							
)	withir To th	Me	29b. Signature and title of certifier 30. Name and address of person who con	m.o.	23a) (Tyna Pri	1	number 1062			signed (Month,	
	Sta	ate	Chad J. Hansen 31. Date filed (Month, Day, Year) EED 9 5 2	M.D. 2401 West 32. Registrar's Signa	Belveder		Baltin	nore MD	212	215	

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 05878 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day MARY ANGELA MELTON February 2004 11:35 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1525 Argonne Drive Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 10, 19 9. Birthplace (State or Foreign Country)
Italy **Funeral** 218-78-3461 87 Director 1916 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 23a or 28e-f show 10d. Inside City Limits the Medical Examiner must be notified at Maryland N/A 1 X Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1525 Argonne Drive 21218 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 years Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 le marked o any injury or other treumatic eve once. Joseph Anello Saveria Pilo. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Allen (daughter) 1525 Argonne Drive Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cemetery 2-24-04 Baltimore, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland enane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** weeks /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed aThe Due to (or as a consequence of): physicien ar Division of Vital Records, P.O. Box 68760, Physiclan/Medical attending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4□Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Seizure disorder 1 Yes 2 No 3 Probably 4 Minknown Completed Dementia 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an has autopsy performed 25. Was case referred to modical examiner? Artery Disease certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 XNo or Attending Physicien: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DQA Medical Certification: To this After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death | Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral C o the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 23, 2004 nedle MO D46504 on who completed cause of death (led 23a) (Type, Print) Dr. Nancy Good Samaritan Hospital Jane Friedley Baltimore MD 21239 31. Date filed (Month. Day, Year) FEB 2 5 2004 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05879 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2:35 A M February 21, 2004 ALICE JOY JAMES McCORMICK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HOSPICE OF BALTIMORE: GILCHRIST CENTER Baltimore County Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct 27, 1919 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 21 F 84 426-03-2856 Mississippi Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat", or Items 23s or 28s-f show any rightry or other traumatic event, the Medical Execution Liver Loudling an once. 1 ☐ Yes 2 No Directo Maryland Baltimore County Lutherville 10e. Street and Number 10g. Citizen of What Country? 21093 606 Brightwood Club Drive USA Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Residence 4 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Beulah Walter Waddell James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type, Print) Mr. Hugh P. McCormick (Husband) 606 Brightwood Club Drive, Lutherville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 2/24/2004 Pikesville, Maryland 21. Signal of Fundal Service License 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 801 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been shown the beautificate. the burial-transit Due to (or as a consequence of) by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2.2 No 1 Yes 2□ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Stother (Specify) NOSQ 1 Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifier 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 00051926 Feb. 21,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SW N. Charles St Bultimore M. Gardon 6565 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 5 2004 FEB Registrar

2:35 AM

DY MCCORMICK

			1- For State of Maryland / Dep Ce	partment of Health and Mental Hy	/giene Reg. No. 2004 05880
I	Physici /Medio		1. Decedent's Name (First, Middle, Last) Florence Joan Di Somma Mullin	2. Date of D Month Februa	eath 3. Time of Death
	Examir	ner	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1.21 2.2 7.0 / 2 1 □ M 2 □ F 6.8 Yrs	Months Days Hours Min. (Month. D.	av. Year) Country
	Director works J	ō	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	April_	23, 1935 New York 10d. Inside City Limits 1 □ Yes 2√1 No
	h with the l	Funeral Director	Maryland Montgomery Rockvill 10e. Street and Number 3 Barkwood Court	10f. Zip Code 20853	10g Citizen of What Country? United States
980	be filed within 72 hours after death with the Maryland ital hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be multied at	by	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	
Maryland 21215-0036	filed within 72 hd Hygiene. other than "natul ent, the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give life.	edent's Usual Occupation a kind of work done during most of working DO NOT use retired) maker	16b. Kind of Business/Industry Own Home
aryland	2 should be file and Mental Hy Is marked oth aumatic event	To Be (17. Father's Name (First, Middle, Last) Gerard Akley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	18. Mother's Name (First, Middle Florence Whit ng Address (Street and Number or Rural Route Numb	e
Baltimore, Ma	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic a once.		Lorraine D. Pender/Daughter 4510 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Arlington 4 Donation 5 Other (Specify)	Jordan Street, Huntingt osition (Name of matter) mattery March 3, tery 2004	on, Maryland 20639 20c. Location - City or Town, State Arlington, Virginia
Rai	permit Depar Impor any in		21. Signature Mineral Service Lidensee M00803 R 23a. Part1. Enter the disease, or complications that baused the death. Do not ent shock, or heart failure. List only one cause on each line.	2. Name and Address of Facility Robert A. Ockville, Inc. 300 West Nockville, Maryland 2085 ter the mode of dying, such as cardiac or respiratory a	Pumphrey Funeral Home/ Montgomery Avenue 0-2805 rrest, Approximate Interval Between
8/60,	Cale be executed Medical Examiner The privile runsit The privi	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):	sin	Onset and Death
O. Box 6	that the death certificate ed by the attending physi detached for use as the l	Physician/Me		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
coras, r	w requires that the been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the ur Thenlin Dependent Didd	10to M. 00. tree	obacco use contribute to the cause of death?
Lec	The law ate has b page 2 sl	e Completed	His tory of C'erebro - Vanenda 25. Was case referred to medical	1 ☐ Yes	prior to completion of cause of death? 1 Yes 2 No
VISION OF VI	or the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director.	ToB	examiner? 1 Yes No Hospital: npatient 2 ER/Outpatien 27 Manner of Death Natural 5 Pending investigation 2 Accident investigation Hospital: npatient 2 ER/Outpatien 2		
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	To the Hospital or within 24 hours after to the Funerat Director Completely filled in	Medical	29a. Certifier (Check only ane) 2 ☐ Medicel Examiner: On the basis of examination and/or invariant manner stated.	vestigation, in my opinion, death occurred at the time, o	cause(s) and manner as stated. date and place, and due to the cause(s) 29d. Date signed (Month, Dey, Year)
	d		Wilkenia Thinala 30. Name and address of person who completed cause of death (Item 23a) (Type, I	" 0 11 110 C.V.	February 21, 2004
ŀ	Sta Registra		31. Date filed (Month, Day, Year) FEB 2 5 2004 Registrar's Signature	stud, #113, si Wersp	ung, Md 20901

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** February 20,2004 J. Nolan 10:30 A. James /Medical 4a: Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Brightview Assisted Living Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 87 06/11/1916 MD Director 215-05-8687 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or Items 23a or 28a-1 show traumatic event, the Medical Example must be notified at 1 Yes 2 No Director MD Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 8810 Walther BLVD Apt. 3626 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ⊠Yes 2 □ No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: If Yes, Give WWII Specify. þ 3 ☐ Widowed 4 ☐ Divorced WHite Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 12 Medical Doctor Medicine permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event QMCs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Mary Peddicord James J. Nolan, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD 21204 James J. Nolan, Jr. 1610 Landon RD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 02/23/2004 Baltimore, MD * 4 □ Donation 5 □ Other (Specify) New Cathedral Cem. 21. Signature of Funeral Service Licensee Sterling Ashton Schwab Funeral Home, Baltimore, MD 21228 9 736 Edmondson Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition eme **Physician** 1291X resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (of as a consequence of). Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year page 2 should be detached for in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo the 9 Unknown 9 Unknown ģ peudis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tale 1 ☐ Yes 2 XNo 3 Probably 4 □Unknown estive 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performeg certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ASSISTED Living 1 ☐ Yes 2 🕱 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1975 41 Keyor WID 10 Ferry Rd, Bultimore MD-21227 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJA MD 4367 Hollins 31. Date filed (Month, Day, Year) FEB 2 5- 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Maryl	and / Depa <i>Ce</i>	artment of F rtificate of	Health and Me Death	ental Hy	giene 20	04 05882
	Physic /Med		1. Decedent's Name (First, Middle, Last		vel5	ON		2. Date of Dea	ath	3. Time of Death
	Exami Funeral Director		4a. Facility Name (If not institution, give 2046) 5. Social Security Number 6. S 220-38-8377 1 Usual Residence of Decedent	PATE A	VE yrs. last birthday) 62 Yrs.	4b. City, Town, of BALT Towns If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	ND 8. Date of Birth (Month, Day 8/10	th (Year)	Death IMOR Birthplace (State or Foreign Country) D:
	aryland show	-	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
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	eath wi	eral C	204 Colgate Av		-115	21222			USA	
9000	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "netural", or items 23e or 28a-f show event, the Medical Examinar must be notified at	þ	11. Marital Status 1 □ Never Married 2∑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)		American Indian, White, etc. White
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Maryland	Mer Mer	10	Joseph Thomas 19a. Informant's Name/Relationship (7)		10h Mailin	- Add (C)	Kathleen			
	12 P		Patricia Nelso	,, -, ,			and Number or Rural i			
Baltimore,	Pages nent of ant: If it	3	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State	ayview	sition (Name of natory or other plac Cremato	Febru Ty 24, 2	ary 004	20c. Location - Cit	re City, MD.
Ba	permit. Departr Imports eny inji		21. Signature of Funeral Service Licent	- Comal	1 ()	onnelly F	uneral Hom rs Point R	e Of Du	undalk.P.	Α.
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the done cause on each line. a. Due to (or as a cons	eath Do not enti	er the mode of dyin	g, such as cardiac or i	respiratory arre	est,	Approximate Interval Between Onset and Death
8760,	icate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons						
.O. Box 6	death certifi e attending id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of predictions of the second of the s	etel death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
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	Physician: this certificantal director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 1000	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA Othe	26. Place of Death (C			Specify)
/ision	ding h. After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At	home, farm, stre		at 28d ? 'es 2 □ No	f. Describe ho	w injury occurred	r Rural Route Number,
ā	pitel or A urs after eral Direc	Cert	TOMICOE	building, etc. (Spe	cify)			City or Town,	, State)	
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Phyone) 2 Medicel Exami	sician: To the best of my k ner: On the basis of exami and manner mated.	nowledge, death nation and/or inve	occurred at the time estigation, in my op	inion, death occurred	at the time, da	use(s) and manne ite and place, and od. Date signed (M	due to the cause(s)
	2		3Q. Name and address of person who co	Impleted cause of death (It	em 23a) (Type, P) Doc	018648	2	2/24	104 BALTO
Е	Sta	te	30. Name and laddress of person who co	O L SEN 32. Registrar's Sig	3	2825 1	10705 1	HARN	(4) -	2/2/9
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	an	1 - State Registrar 1. Decedent's Name (First, Middle, Last) Michael R. Naypo					2. Date of Deat Month Februar	h Dav Yea	3. Time of Dea
/Medic		4a. Facility Name (If not institution, give st.			4h City Town	or Location of Dea		4c. County of De	
Examili	iei	3533 Pelham Aver			Balti			N/A	7411
Funeral Director		OMITTIOWITY 1.	7. Age	(In yrs. last birthday, 71 Yrs.	Months Days			Year) 9. B	lirthplace (State or Fo Country) OHIO
A H		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Li
ms 23s or 28e-f show	tor	MD. N/A		BAL	TIMORE				1 ⊡X Yes 2 ⊡
r 28e	Director	10e. Street and Number			10f. Zip Code	li e	10	og. Citizen of What	Country?
238	rai	3533 PELHAM AVI	ENUE		212	13		U.S.A.	
ltems Term	Funeral		2. Was Decedent E Armed Forces?)	Was Decedent of If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh	nerican Indian,
tural', or ite al Examine	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 🔀 No	Specify:		Specify: W]	HITE
natura Jical E	ted	15. Decedent's Educa	ition	16a. Dece	dent's Usual Occu	pation		16b. Kind of Busines	ss/Industry
Man "	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	life	kind of work done DO NOT use retire	e during most of wo ed)	rking		,
ygiene. her than it, the b		12		SALI	ESMAN			HARDWARI	E RETAIL
Department of Health and Mental Hygiene. Importent; or items 23s or 28e-f show importent: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumatic svent, the Modical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last) MICHAEL M. NAYPO	MED				me (First, Middle, M	laiden Sumame)	
d Mental marked o matic sve	2	19a. Informant's Name/Relationship (Type		10h Maili	Add (Ot	AGNES	SUPERK		
Ith and 27 is ma trauma						-		City or Town, State,	e de la companya de l
f Health Item 27 other tra		ETLEEN M. LORAH 20a. Method of Disposition		20b. Place of Dispo	FRANKL]		PALMERTO Date 2	N P A 1 C	or Town, State
nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer `4 ☐ Ponation 5 ☐ Other (Specify)	noval from State		matory or other pla IOUNT CF	^{ece)} FEB. REMATORÝ	24.2004	ALTIMORE	
Department Importent: any injury c		2 Sonature of Funeral Service Licensee	1/	1		1			
Depa Impo any ir	1	Ilmadine	10 81	10 W 1	412 E.	PRESTON	GS FUNE ST. BA	RAL HOME LTO,MD.	21213
		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused to	the death." Do not ent	er the mode of dy	ing, such as cardiad	or respiratory arre	st,	Approximate Interval Betwee
nysician		Immediate Cause (Final disease or condition	Myo	CARST	250	INFAR	CAT 01		Onset and Dea
Medical xaminer		resulting in death)	Due to (or as a	consequence of):	0.00	- 4			
in gra	-	Sequentially list conditions, b.	Due to (or as a	ER 21	11/6	MIN			
nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	11-0-	F 87 8 3 2 1	V3102	2			
ician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):	V / 1 0 14				
hysician the buria		d							
ng ph as th	Medi	IC CCMM C							
Ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome o		Ectopic pregnanc	ev.		23d. Date of de	•
the at hed fo	sici	1 Ves 2 No	4□Pregnant at ti 9□Unknown		Other (specify) _	·		Month	Day Year
ed by the detached		Part II. Other significant conditions contri	huting to death but	not reculting in the w	adashina nawa aw		07a Didasha		
signed d be del	Completed by	PERCENERS	\ A	ZAERA		UDEASE	_ []	icco use contribute t	o the cause of death robably 4 ⊟Unkr
been si	ete	METRADUE							
page 2	d L	NETAYORC	2900	17 POINC			24a. Was an autopsy performe	prior to	utopsy findings avai completion of cause
certificate ector, pag	Č.	25. Was case referred to medical				00.00		No 1 □ Ye	s 2 No
w E	0	examiner?	spital:	2 ER/Outpatien	t 3CLDOA Ott		th (Check only one)	ce 6 ☐Other (Spe	
£ _	ī.	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day	the second secon	28c. Injui	ry at	28d. Describe how		schy)
death. ctor: Af y the fur	äti	2 Accident investigation	(,)	. saly		Yes 2 □No			
after death Director: / I in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stre	et and Number or R State)	ural Route Number,
urs aft ore! Di	ca	29a. Certifier Check only one) Certifying Physic 2 Medical Examiner	: On the basis of e	xamination and/or inv	occurred at the til	me, date and place, opinion, death occur	, and due to the cau rred at the time, date	se(s) and manner as	s stated. e to the cause(s)
Funer Funer	=	Une)	and manner state	9d.					
Funer Funer	Medical	29b. Signature and till certifier			29c. Licens	se number		Data cinned /Mon	th Day Voor
in 24 hou he Funer pletely fill	Medi	29b. Signature and title certifier	111	7		3967		Date signed (Mont	

			For State Registrar	State	of Maryla		artmen <i>rtificati</i>			Mental H		2004	05884
	Physici	an	1. Decedent's Name (First, Midd							2. Date of E Month	eath Da	y Year	3. Time of Death
	/Media		Catherine O'I							Februa		, 2004	1:30 AM M
1	Examin	er	4a. Fecility Name (If not institution		um <i>ber)</i>		4b. City,		Location of Dea	ith	40	. County of Dea	th
			224 S. Carey 5. Social Security Number	6. Sex	7. Age /ln vrs	. last birthday)	If Under		Ltimore If Under 24 Hrs	s. 8. Date of B	irth	9 Bir	thplace (State or Foreign
Н	Funeral Director		217-54-6361	1□M 2∏F		2 Yrs.	Months	Days	Hours Mir	Apr 15	ey, Year 19	51 Ar	cuntry) kansas
14	ס		Usual Residence of Decedent				1			-			
	arylar show	B	10a. State 10b. County	1	10c. C	ity, Town or Lo							10d. Inside City Limits
	8a-f	Director	MD			Balt	imore						17 Yes 2 No
	with th	ă	10e. Street and Number 224 S. Carey	Ctroot			10f. Zip	Code 21223			10g. Cit	tizen of What Co USA	ountry?
	eath	eral	11. Marital Status		cedent Ever in t	IS 13 1				Specify Yes or N	10-	14. Race - Ame	arican Indian
Maryland 21215-0036	d within 72 hours after death with the Maryland Jiene r than "netural", or itams 23a or 28a-f ehow Ita Medical Eraninar must be motified at	by Funeral	1 Never Married 2 Mai 3 Widowed 4 Divorce	ried 1 Yes	Forces? 2XINo Bive		I Yes, spec	ofy Cuban	Specify:	rto Rican, etc.)		Black, Whit	
2-0	72 ho	Completed		nt's Education	()	16a. Dece	dent's Usua	il Occupat	tion uring most of we	ndkina	16b. K	and of Business	/Industry
2		nple	Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	DO NOT us	e retired)		Jinnig			
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anc	V & A &	Be	17. Father's Name (First, Middle Keith O'Dell	Lasi)						ame (First, Middi :h Hubbs	e, <i>Maid</i> en	Sumame)	
Ë	should be and Menta markad umatic ev	ဥ	19a, Informant's Name/Relation	shin (Tyne Print)		19h Mailir	ng Address	(Street as		Rural Route Num	har City	or Tourn State	Zin Cada)
Za	nd 2 shoulth and 27 is m		Sandra O'Dell			1				t Baltin			
	1 2/1		20a. Method of Disposition		20b.	Place of Dispo	sition (Nan	ne of		Date		ocation - City or	230 Town, Stete
OE.	Page: ento nt: if i		1 ☐ Burial 2 ☐ Cremation 14 ☐ Donation 5 ☑ Other (3	3 □Removal from Specify) in si	n State	cemetery, crer	natory or of	iner piace	' i				
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Sign ture of Funeral Shrice			r St	Name and	nato	my Boar	d 655 W	. Bal	timore	Street
			23a. Part1. Enter the disease, o	complications that	caused the dea	Da		re.	צו ב	O I			Approximate
7	Physician		shock, or heart lailure. Lis Immediate Cause (Final	t only one cause on	each line.	0							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	o (oreas a conse	quence of):	ev_						Lyear
*	Examiner		Conventially that are divine										
100	D .≅	iner	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(bras a ouriso	quanna ut)r							
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.									
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68760,	physic the	dical		d									
Box	e death certifi he attending led for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live	utcome of pregn birth 2 Fet gnant at time of	aldeath 3 [Ectopic pre					23d. Date of del Month	ivery Day Year
P.O.	that the dened by the a		9 ☐ Unknown Part II. Other significant conditi	one contribution to	dooth but not so	aultina in the cu	a al a ub dia a a a		in Don't	Oo Did	4=1		Ab
Records,	The law requires that the ate has been signed by the page 2 should be detache	ted by	Circho	sis		suring in the ur	iderlying ca	use giver	in Pan I.				the cause of death?
l Rec		Completed	Mech	ol Abu	se					24a. Wa auto perl 1 ☐ Yes		prior to death?	topsy findings available completion of cause of 2 No
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	7						ath Check only			
Division of Vital	Q 5 D	2	1 ☐ Yes 2 ☑ No 27. Manney-ol Death		Inpatient 2					Home 5 Dres			cify)
nc	After After funer	lo l	1 ☑Natural 5 ☐ Pendi	19	nth, Day Year)	28b. Time of Injury	M 28	Bc. Injury a Work?		28d. Describe	how injur	y occurred	
isi	f or Attending after death. Director: After in by the fune	licat	3 Suicide 6 Could		ce of Injury - At h	nome farm stre			s 2 No	28f Location	Street an	d Number or Pr	ral Route Number,
<u>≥</u>	s after il Dire	Certification:	4 Homicide determ	buil	ding, etc. (Speci	fy)	sor, raciory,	Onice		City or To	wn, State)	rai noule Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Certifyin (Check only one) 2 Medicel	ng Physician: To the Examiner: On the and ma	ne best of my kn basis of examina nner stated.	owledge, death ation and/or inv	occurred a restigation,	at the time in my opir	, date and place nion, death occi	e, and due to the urred at the time	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifie	or /	,		29c.	License	number		29d. Dat	e signed (Month	n, Dey, Year)
			Mil -	- Sue	1		1	243	3574		2	116/0	4
			30. Name and address of person	7 516	5 C721_	40			/			1	1
2	Sta Registr	_	31. Date liled (Month, Day, Year, FEB 2 5	2004	Registrar's Sign	ature 2							

			For State Registrar	of Maryland / Dep Ce	partment of Health and Mertificate of Death	1109.110.	04 05885
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Roy Charles	okan okan		2. Date of Death Cebruary 20, 20	3. Time of Death 1:50 AM M
	Examin		4a. Facility Name (If not institution, give street and r Northampton Manor Nu		4b. City, Town, or Location of Death Frederick	4c. County of Frede	
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthday 76 Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Year)	9. Birthplace (State or Foreign Country) 1innesota
	faryland show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick	10c. City, Town or I Frederi			10d. Inside City Limits 1 X Yes 2 □ No
	with the h	Direct	10e. Street and Number 613 Rosemont Ave.		10f. Zip Code 21701	10g. Citizen of Wh	
36	be filed within 72 hours after death with the Maryland tal Hyglene. id other than "natural", or items 23a or 28e-f show event, I're Madical Examinat must be natified at	by Funeral Director	11. Marital Status 12. Was De	Sive WW II	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 □ Yes 2 No Specify:		- American Indian, , White, etc. White
Maryland 21215-0036	within 72 hou iene. r than "natura ire vical E	Completed	15. Decedent's Education (Specify only highest grade complete) Elementary/Secondary (0-12) College +5	d) (Giv	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired! Cher/Administrator	16b. Kind of Bus School	
land 2	ed a b	To Be C	17. Father's Name (First, Middle, Last) Obert B. Okan			(First, Middle, Maiden Sumame, n Hoitomt)
	d 2 th a		19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Jane Okan, wi		ling Address (Street and Number or Rura Rosemont Ave., Fre		
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 Ocemation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Smithsbu	ematory or other place) irg Crematory Feb.	21, 2004 Smith	ity or Town, State asburg, MD
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Linensee	MOO255 1	eeney and Basford I O6 East Church St.	PA Funeral Home Frederick, M	D 21701
	Medical Examiner price sician and price	ai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Normal	produce h	gel co ceptal	Approximate Interval Between Onset and Death
P.O. Box 68760	ne death certificate the attending phys thed for use as the	Physician/Medicai	23b. Was decedent pregnant	gnant at time of death 5	□Ectopic pregnancy □ Other (specify)	23d. Date Monti	
of Vital Records, P.	w requires that the control of the c	Completed by Ph	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.	3	3 Probably 4 □Unknown
al Re		e Comp	25. Was case referred to medical		Of Plant of Parish	performed? de 1 ☐ Yes 2 ☐ No 1 ☐	ere autopsy findings available or to completion of cause of ath? Yes 2 No
	ng Phys tter this neral di	To B	examiner? 1	Inpatient 2 ER/Outpaties of Injury 28b. Time Injury	of 28c. Injury at 2	ne 5 Residence 6 Other	
Division	itel or Attencts after death all Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Pla bui	ce of Injury - At home, farm, s ding, etc. <i>(Specify)</i>	street, factory, office	t8f. Location (Street and Number City or Town, State)	or Rural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai	(Check only 2 Medical Examiner: On the one)	he best of my knowledge, dea basis of examination and/or anner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	ed at the time, date and place, an	d due to the cause(s)
	with To I	2	29b. Signature and title) of pertitier	watt	29c. License number		(Month, Day, Year) y 20, 2004
	B		30. Name and address of person who completed ca	use of death (Item 23a) (Type	300 W 9th So	+ Freder	y 20, 2004 rck MD
	Sta Registr		31. Date filed (Month, Day, Year) 32.	Registrar's Signature	book		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 State Registrar AMEND ITEM #18 PER FH G828 2/26/04 CHARTIFICATE OF Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** PULLER 6:00 A M HELEN FEBRUARY 24 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ANNE ARUNDEL CO. MARINER HEALTH OF NORTH ARUNDEL GLEN BURNIE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, **Funeral** 07-02-1917 Director 86 Mary1and 215-18-7988 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ahow Tre Madical Examinat must be notified at 1 ☐ Yes 2 No Director Glen Burnie Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21060 United States 7754 Overhill Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. δ White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene, marked other than Presser Pilgrim Laundry 10 years permit. Pages 1 and 2 should be filed w Department of Heath and Mental Hygier Important: If Item 27 Is marked other It any injury or other traumatic avent, ILS ODGS. 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဥ Unknown ELLA WALTON Walton Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard W. Puller, Jr. (Son) 7754 Overhill Road Glen Burnie, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-26-2004 Cedar Hill Cemetery Brooklyn Park, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa ure of Funer ILS rvice Lice McCully-Polyniak Funeral Home, P.A. mo0922 130 E. Fort Ave. Baltimore, Maryland 21230 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or head failure. List only one cause on each line. Approximate Interval Between Onset and Dea Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner The law requires that the death certificate be executed and physicien an Due to (or as a consequence of): Box 68760 Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year 5 Other (specify) P.O. ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has 928 s certificate ha 25 No 1 Yes 2 No 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Laursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 No 2 his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: , 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 2 16 4 4 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Actoudy h 30. Name and address of person who completed cause of death (Item 23a) (Type 8021 RITCHIE UNY PASADENAMD 21 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 5 2004 Registrar

	an	Decedent's Name (First, Middle, La Walter Vladi	Matrer AT		Perkowetz		2. Date of Month Febr	Death Day	Year 2004	3. Time of Death 5:50 a. M
/Medic		4a. Fecility Name (If not institution, giv	e street and number)	_	4b. City, Town,	or Location of		4c. County	of Death	
	\$11	Gilchrist Cente		I A Citate de la S	To	WSON	Hrs D D-1- of			re Co.
ineral rector		5. Social Security Number 6. S 215-30-0616 1 Usual Residence of Decedent	7. Age (In yrs. 80		Months Days		Min. Sept.	Birth Day, Year) 23, 192	3. Birthp Coun	lece (State or Foreigr try) Poland
If item 27 is marked other than "natural", or Items 23e or 28e-f show or other treumatic event, the Medical Examinational be nettified at	_	10a. State 10b. County		y, Town or Lo			-		11	0d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1
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T P	DI DI	2419 Kentucky	Avenue			213			ted S	•
ANT TREETING	Completed by Funeral Director	11. Marital Status 1 Never Married 2 🏋 Married	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 🛣 No				n? (Specify Yes or Puerto Rican, etc.)	No- 14. Rad Bla	ce - Americ ck, White, e	etc.
	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		I□Yes 2🗖 No			Specif	y: W	hite
	letec	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Deced (Give	lent's Usual Occu kind of work done OO NOT use retire	ipation or during most of ad)	f working	16b. Kind of B	usiness/Inc	lustry
	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		Real Est			Rea	l Est	ate
Vent,	Be C	17. Father's Name (First, Middle, Last,)	<u> </u>		18. Mother's		dle, Maiden Sumar	ne)	
	2		erkowetz	450 14 10		Ire		tzko		
		19a. Informant's Name/Relationship (Mrs. Katherine Per			g Address <i>(Stree</i> Kentuck			nber, City or Town. Cimore, M		213
otner		20a. Method of Disposition	20b. P		sition (Name of natory or other pla		Date	20c. Location		
ary or		1 XX Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specif	st.	Andre			27/2004	Dunda	alk, M	Maryland
any injury once.		21. Signature of Funeral Service Lice	Michael E. Cana	app ²²	Name and Addr Coriand J.	1000		305 Harf Saltimore		oad 21214
ian		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	lications that caused the death one cause on each line.	n. Do not ente	-	-			2	Approximate Interval Between Onset and Death
dical niner		resulting in death)	Due to (or as a conseq	uence of):	Ord	sici	2	CHUCER		menths
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attending physician and for use as the burial-transit	cal		d							
use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta		Ectopic pregnanc			23d. Da	te of delive	ry
ached for	hysicle	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of do		Other (specify)			- Mc	onth	Day Year
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ed bluor	౼							topsy rformed?	Were autop prior to con death? 1 Yes	esy findings available apletion of cause of 2 \(\subseteq \text{No} \)
shou	Com					_		v one)		(200
shou	Be Completed	25. Was case referred to medical examiner?	Hooritali.				Death (Check onl	, 0.1.07		17
shou	To Be	examiner? 1 Yes	28a. Date of Injury (Month, Day Year)	ER/Outpation 28b. Time of Injury	28c. Inju	her: 4 Nursi	ng Home 5 Re		ner (Specify red	Hospice
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DHMH 17 Rev 1/2001

2/24/04@ 554M

PERKOWETZ, WALTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O. S.

December 1 services Property Services Property			•	- For Amend Item 1 per Dr. Registrar	,G828,02/25/0	O4dhb Cei	rtificate of l	Death	entai riye	eg. No.	4 05888
Provided Comment of Co		Physicia	an.	Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
Considerable March & Allerty Level And Allerty Level 1000 (Allerty March 1000 (Allerty	75	/Medic	al	Jeon Fertins		Perkin		Location of Death	0 2		<u> </u>
Second South Number Column Second South Number Column Second South Number Se		Examin	er			nter					••••
To Sine I to Court No. Sine To Court				5. Social Security Number 6. Sex 10x 218-84-1643	7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey Aug. 21	, Year) 9. Bi	Country)
Specific Continues Continu		land ow			10c. City	y, Town or Lo	cation				10d. Inside City Limits
Specific Continues Continu		Mary Fe eho	to	Maryland Harford			Abingdo	n			1 ☐ Yes 2XXXIo
Specific Continues Continu		or 284	Oirec				10f. Zip Code		1	10g. Citizen of What C	Country?
Specific Continues Continu		sath w			Decedent Ever in II	S 12 1			city Ves or No-		erican Indian
Specific Continues Continu	0	r Item	Fun	1 Never Married 20XMarried 1	ed Forces? Yes 2 XX No	1			Rican, etc.)	Black, Wh	
Specific Continues Continu	2	ours a	þ	3 ☐ Widowed 4 ☐ Divorced Year	s, Give r or Dates:					V	
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Physician (Machine Park) Physician (Machine	Ĕ	ment tant: I tant: I		24 □ Donation 5 □ Other (Specify)					-		
Physician (Medical Examinor) Physic	Ba	permit Depar Impor any in			DOM to						
Pinysician / Machiner The sequencial state of the state	÷			23a, Part1, Enter the disease, or complications	that caused the death						Approximate
Due to (or as a consequence of): Securitally list conditions contributing to management of the security of		Physician		Immediate Cause (Final disease or condition		atey	distan				Onset and Death
THE TOTAL TO THE PROPERTY OF T	6.				ue to (or as a consequ						
Section Sect		uted 1 ansit	miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequ	uence of):					
FFEMALE: 23d. Date of delivery 23d. Date of deli	,09	be execticion and burial-tra			ue to (or as a consequ	uence of):		-			
FEMALE: 15 15 15 15 15 15 15 1	687		edlc	d							
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25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Margner of Death 1 Natural 2 Na	₽.	uires that signed by Id be deta	þ	Part II. Other significant conditions contributing	g to death but not resi	ulting in the u	nderlying cause giv	en in Part I.		/	
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 31. Date filed (Month, Dey, Year) 32. Registrar's Speature	İta	ilan: artifica ctor, p		eyaminer?						/	
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AGUSTAL ELB A GUOT ST		Sta Registi		31. Date filed (Month, Dey, Year) FFB 2 5 2004	32. Registrar's Stora	ture					

State of Maryland / Department of Health and Mental Hygiene 2001.

					Cer	tificate of	Death	Re	g. No. Z. U	04	05889
			1. Decedent's Name (First, Middle, Last)					2. Dete of Deetl Month	Dey	Year	3. Time of Death
	Physic /Medi		Daniel A. Quirk, Sr	•				Februar			6:20 AM
	Exami		4a Fecility Neme (If not institution, give st	reet end number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
			Manor Care Potomac				Potomac	,	Montgo		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Yeer)	 Birthpla Countr 	ace (State or Foreign ry)
	Director		149-07-3504 Usual Residence of Decedent	96	113.			July 19	, 1907	New J	Jersey
	end ***		10a. Stete 10b. County	10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits
	Mary	0	D.C. None	Mooh	inatan	D C					1)X Yes 2□No
	158 the	Director	10e. Street end Number	wasii	ington	10f. Zip Code		10	og. Citizen of V	Vhet Countr	ry?
	3a or	ᅙ	1505 R Street, NW			20009		II	nited S	Statos	
	death 2	Funeral		. Was Decedent Ever in U	,S. 13. V	Vas Decedent of	Hispanic Origin? (Sp	ecify Yes or No-	14. Race	e - Am <i>e</i> rical	n Indian,
5	The state of the s		1 Never Married 2 Married	Armed Forces? 1 □XYes 2 □ No		- 1. 1. 1. 1.	oan, Mexican, Puerto	Hican, etc.)		k, White, et	ic.
Maryland 21215-0020	filed within 72 hours after death with the Marylend Hygiene. ther than "natural", or flems 23a or 25a-f show ant, the Medical Exement must be notified at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates: WW I	ı	I□Yes 2XX No	Specify:		Specify	Wh	nite
ה ה	72 ho	Be Completed	15. Decedent's Educa (Specify only highest grade of		16a. Deced	lent's Usual Occu	pation during most of work	tina	16b. Kind of Bu	siness/Indu	ıstry
7	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	OO NOT use retire	9d)				
V	ygier f, th	ò	12		Cros	sing Gua			Municip		
2	d tal al	Be	17. Father's Neme (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N	faiden Sumam	θ)	
7	Ould Men Merka	ို	Richard Quirk				Alice Ca				
Nai	is m		19a. Informant's Name/Relationship (Type				t and Number or Rui				20de)
ני מ	l end lealth m 27 her t		Daniel A. Quirk, Jr			R St., N sition (Name of	W, Washin		C. 2000 20c. Location -		m State
5	ges if of h		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Rei			natory or other pla					
	tmen tant: tant:		4 □ Donation 5 □ Other (Specify)			1 Cemete		27, 2004	Tenaf	1y, N	IJ
paitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a or 28a-1 show any highry or other traumatic event, the Medical Examiner mant be notified at once.		21. Signature of Funeral Service Licensee	#CC0321	Ba:	. Name and Addr rrett fu	ess of Facility neral Hom	e			
	40 = 60		Mancy 1	resselle			rive, Ten				
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	tions that caused the deat cause on each line.	h. Do not ente	er the mode of dy	ing, such as cerdiac	or respiratory arre	est,	1	Approximate Interval Between Onset and Death
	hysician										onset and Death
# 	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a.	Colo	NC	ano	er			i	YRS
		-		A Due to (c	or as a conseq	uence of):	11 1)	10
	nsit	n in	≠ b.	NTTIA		1000	dayi	M			XK2
_	mecu el-tra	xar	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	Due to (d	oras a con(s)equ	uence of):				1	
00/00	siciar buni	edical Examiner	Cause (Disease or injury that initiated events	Dua to /o	r as a consequ	uongo of):					
0	eath certificete be executed attending physician end for use es the bunel-transit	8	resulting in death) Last	0) 01 800	as a consequ	dence on.					
		M	d								
	The lew requires that the death c ate has been signed by the attenc page 2 should be deteched for us	Physician	Part II. Other significant conditions contri	buting to death but not res	ulting in the un	nderlying cause g	iven in Part I.	23b. Did tol	becco use con	itribute to 1	the cause of death?
5	of the by the stache	چَ						1 ☐ Ye	s 2 No	3 Proba	ably 42 Unknown
'n	gned be de	þ									
2	aquire en si ould	<u>8</u>						24a. Was ar perform		avail	e autopsy findings lable prior to
נ	as be	를								of de	pletion of cause eath?
	The I	Completed						1□Ye	s 2K(No	1 🗆	Yes 2000
9	Physician: r this certifica ral director,	Be (25. Wes case referred to medical examiner?					h (Check only one	9)		
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DIVISION OF VITAL RECOIDS, F.O.	ng Pl fterti	ü	27. Manner of Deeth 1 Natural 5 □ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju		28d. Describe ho	w injury occurr	ed	
2	Attanding or death. Sector: After by the fune	catt	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be]Yes 2□No				
E	or Att	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre y)	et, factory, office		28f. Location (Str City or Town		er or Hurai i	Houte Number,
_	oral C	ဝ	29a. Certifier 1 Certifying Physic	less. To the best of my less	wlades dooth	analystad at the t	ima data and slave				tod.
	Hos 24 ho Fun etely	edicai	(Check only one) 2 Medical Examine	lan: To the best of my kno r: On the basis of examina and manner stated.	tion and/or inv	restigation, in my	opinion, death occur	red at the time, da	ite and place, a	and due to t	ted. the cause(s)
	To the Hospital or Attanding Physician: The lew within 24 burus effer death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	ĕ ≅	29b. Signature end title of certifier	-()			se number		d. Date signed		
	⊢≱≓ŏ		XI	Km.				F	FBRUK	IRY	20.2004
	٦	-	30. Name and address of person who com	pleted cause of death (Item	1 23a) (Tyna 1	Print)	- 110			11 1/	, ,
	\		SWAROOP. G. R	40, 50 W	I-ED	MONS	TON 3	DR, Re	ockvi	LE	20,2004 F, MD
	Sta Registi	100	31. Date filed (Month, Day, Year) FEB 2	32. Registrar's signa 5 200	eses d	Sheet	2				

		1	For State Registrar AMEND TTE	v #2	State of Ma	ryland / l	Depa и Св и	irtment of H tificate of I	leaith and M <i>Death</i>		giene _{Reg. No.} 2	004	058	390
			. Decedent's Name (First, Middl		IIIX IIII GOZ	27 3/10/0		•		2. Date of De Month	ath 02/19	/2004	3. Time of D	eath
	ysicia	n	Lewis Robert							2/18/	,	1 001	6:50	A M
	Medica Camine		a. Fecility Neme (If not institution	, give str	reet and number)			4b. City, Town, or	Location of Death	27 107		unty of Deeth	0.30	21.
E.X	amme		4901 Ten Mil.		oad	(In yrs. last bi	rthday)		If Under 24 Hrs.	8. Date of Bir	th	ward 9. Birth	plece (State or i	Foreign
	eral				M 2□F 60		Yrs.	Months Days	Hours Min.	(Month, Da				
Dire	CLOI		415-58-6096 Usuel Residence of Decedent		100					01/02	11943	101		1.1
/land	Ħ		10a. State 10b. County			10c. City, Tov							10d. Inside City 1 ☐ Yes 2	
Man	fled	to	MD Howa:	cd		Colum	bi	a						
with the	De rivi	۵	10e. Street and Number					10f. Zip Code				of What Cor		
eath s 23	1871	era	4901 Ten Mil 11. Marital Status	Ls_R	Coad 2. Was Decedent B	ever in U.S.	13.	21044 Was Decedent of F	lispanic Origin? (Sp	ecify Yes or No	- USA	Race - Amer	rican Indian,	
72 hours after death with the Maryland naturel: or Items 23a or 28a-1 show	Evanirier must be nightfoot at	by Funeral	1 □ Never Married 2 □ Mai 3 ₩ Widowed 4 □ Divorced	ned	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			lf Yes, specify Cubi 1 □ Yes ②◯\ No	an, Mexican, Puerto Specify:	Hican, etc.)		Black, White ecify: Bla	, 0.0.	
72 hours af	dical Ex		15. Deceder	t's Educ	ation	168	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing	16b. Kind	of Business/I	industry	
		Completed	Elementary/Secondary (0-12)		College (1-4or 5	rs S			stems Ar	nalyst	Nucl	ear F	missic Regulat	on Cory
B = 1 =	cevent	Be	17. Father's Name (First, Middle						18. Mother's Nam					
aryland should be t and Mental I	it mati	6	Lemuel Rober 19a. Informant's Name/Relation			19	b. Maili	ng Address (Street	and Number or Rur	ral Route Numb	per, City or To	own, State, Z	(ip Code)	
and 2	rtra		Lazania Phil	pot	t/daugh		5 - Total Contract Co	The second secon	ot Lane,					
es 1	ry or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (3 □Re	emoval from State	cemet	ery, cre	osition (Name of matory or other pla a Membat	ce)	Date 4/2004		ion - City or Cksvi	llle, I	MD.
Baitim permit. Pag Department	eny injury once.		21. Signature of Funeral Service	$-U_{ij}$			2	2. Name and Addre	ess of Facility Wit	Rd Co	lumb.	L Home	es,Inc	• 45
	16-		23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final	r complic only on	ations that caused e cause on each li	the death. Done.	not en	ter the mode of dy	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Betwoonset and Do	veen eath
	ician dical niner		disease or condition resulting in death)	C a		a consequenc			<u> </u>				omom	197
Z.N		iner	Sequentially list conditions. if any, leading to immediate cause. Enter Underlying) •	Due to (or as	d consequenc	a ut).	V						
	icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as	a consequenc	e of):							
ate	9 9	edical		d										
Records, P.O. Box 60 The law requires that the death certific	the attending property of the distribution of	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2:	3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal dea		□Ectopic pregnand □ Other (specify)	су		230	d. Date of del Month	•	'ear
ds, P.	signed by the a d be detached f	by	Part II. Other significant condi	tions con	tributing to death b	out not resulting	j in the	underlying cause g	iven in Part I.		tobacco use		o the cause of de robably 4 🗀 U	
Vital Records, sician: The law requires t	page 2 should	Completed								24a. Wa aut per 1 Yes	opsy formed?	24b. Were as prior to death?	utopsy findings a completion of ca	ivailable iuse of
	certificate rector, pag		25. Was case referred to medi	al					26. Place of Dea					
Sicia	s cert lirect	o Be	examiner?		lospital:	ent 2 ER/	Outpatio	ent 3 DOA	ther: 4 Nursing H	lome 5 Re	sidence 6 (Other (Spe	ecify)	
Vision of Vital Attending Physician:	After this certific funeral director,	lon: To	27. Manner of Death		28a. Date of Inju (Month, Da		. Time Injury	W	ury at ork? □ Yes 2 □ No	28d. Describe	e how injury	occurred		
Division of tor Attending Physatter death.	Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Cou	d not be mined	28e. Place of In building, e	ijury - At home. tc. (Specify)	, farm, s	street, factory, office		28f. Location City or T	(Street and lown, State)	Number of R	ural Route Numi	ber,
To the Hospitel	To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only ane) Certif	ring Phy al Exami	sician: To the besi ner: On the basis of and manner s	of examination	dge, dea and/or	ath occurred at the investigation, in my	time, date and place opinion, death occu	e, and due to thurred at the time	e cause(s) a e, date and p	nd manner a lace, and du	s stated. e to the cause(s)
o the	omple	Me	29b. Signature and title of cert	ier				29c. Licer	nse number		29d. Date	signed (Mon	th, Day, Year)	
F 3	- ()) CR					24	1139		Febr	ray 1	97,2	004
	9		30. Name and address of pers		ht-1106	55 Lit	tle		nt Pkwy,	Colu	mbia,	Md.2	1044	
	Si Regis	tate trar	31. Date filed (Month, Day, Ye FEB 2			trar's Signature		book						

	For Unpend Item# State Registrar	Ziate of Maryland / L	cepartment of Health and I 328-2/27/04eg Certificate of Death	Reg. No.	2004 05891
	1. Decedent's Name (First, Middle, Last)	.1 0		2. Date of Death Month Day	3. Time of Death Year
ı	ANNIE Elizob	eth Koss_		February 13	. 2004 0855 P. M
1	4a. Facility Name (If not institution) give st	reet and number)	4b. City, Town, or Location of Death	1 4c. 0	County of Death
ger i	1607 McHenry Stree	t	Baltimore		NA
1-3	5. Social Security Number 6. Sex	M 2XF 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9 Birthplace (State or Foreign Country)
	70-10-014.1	7 00	113.	01-05-1	1 V H
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
5	MD NIA	HO	Himopo		12 Yes 2□No
מ	10e. Street and Number		10f. Zip Code	10g. Citiz	en of What Country?
2	1600 MCHENRY	Street	21223		USH
	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer		Race - American Indian, Black, White, etc.
2	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 No Specify:		Specify: DIM
ב כ	3 Widowed 4 □ Divorced	Year or Dates:		101 15	DIHUK
piele	15. Decedent's Educ (Specify only highest grade		Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)		d of Business/Industry
Ē	Elementary/Secondary (0-12)	College (1-4or 5+)	MISTOMIAN	Bo	itto City
3	17. Father's Name (First, Middle, Last)	1011	18. Mother's Nat	me (First, Middle, Maiden	Sumame)
ם כ	DEWEY MARK	=1/	Alva	=o+a Cae	es/
-	19a. Informant's Nameelationship (Type	DB (Print) 19b	. Mailing Address (Street and Number or Ri	ural Route Number City or	Town, State, Zip Code)
	William Ross	(Son) κ	OT MCHENRY S	treet Bat	former MD 2122
	20a. Method of Disposition	. comete	Disposition (Name of ry, crematory or other place)	Date 20c. Loc	cation - City or Town, State
	1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	HUS COMPTERVICE:	21-04 Pa	Himoro, MD
	21. Signature of Funeral Service License	90	22. Name and Address of Facility	ughn C Gre	ene Funeral Service
	Mugh	yn.	5151 Batto. NOT!	Piko Batt	mure, mp 21229
П	23a. Part1. Enter the disease, or complice shock, or heartfallure. List only on	cations that caused the death. Do	not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
	Immediate Cause (Final disease or condition	Pneumonia			Onset and Death
	resulting in death)	Due to (or as a consequence	of):		
	Sequentially list conditions)			
ner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying	Due to (or as a consequence	of):		
ше	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):		
<u> </u>	resulting in south, East	Due to to as a consequence	or).		
dicai Examinei					
a)	IF FEMALE:	3c. If yes, outcome of pregnancy			3d. Date of delivery
ian	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)		Month Day Year
Physician/M	1 ☐ Yes 2/≦No 9 ☐ Unknown	9 Unknown			
	Part II. Other significant conditions con	ntributing to death but not resulting	n the underlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
Completed by				1 □ Yes 2 ₺	No 3 Probably 4 Unknown
iete				24a. Was an	24b. Were autopsy findings available prior to completion of cause of
THC.		-		autopsy performed? 1⊠Yes 2□No	death?
Be Co	25. Was case referred to medical		26. Place of De	ath (Check only one)	
08	examiner? 1 X Yes 2 □ No	Hospital: 1 Inpatient 2 ER/O	utpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6	Mother (Specify At scene
n: J	27. Manner of Death 1 Natural 5 Pending		Time of 28c. Injury at linjury Work?	28d. Describe how injury	y occurred
atio	2 Accident investigation		M 1 Yes 2 No		
tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (Street and City or Town, State,	d Number or Rural Route Number,)
dicai Certification: To					
G	29a. Certifier 1 ☐ Certifying Phys (Check only 2 🕅 Medical Exami	sician: To the best of my knowledg ner: On the basis of examination a	e, death occurred at the time, date and place nd/or investigation, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	place, and due to the cause(s)

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

29c. License number OCME

29d. Date signed (Month, Day, Year) February 14, 2004

30. Name and address of person who completed of the of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 SUSAN HOGAN

State Registrar 29b. Signature and fitte of certifier

32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2

parks

State of Maryland / Department of Health and Mental Hygiene 2001

			1 - State Registrar		C	ertificate of	Death	Re	19. No. 2004	05892
-70	Physici		Decedent's Name (First, Midd	Charles F	Reese Rog	gers		2. Date of Deat Month FEBRUAR	Day Year	3. Time of Death 4:21P. M
	/Medio Examir		4e. Facility Name (If not institution SHOCK TRAUMA CE	n, give street and number)			or Location of Deat		4c. County of Death	
is the	Funeral Director		5. Social Security Number 220.20.4952	6. Sex 1 M 2 ☐ F	e (In yrs. last birthd 76 Yrs	Months Days			Year) 9. Birth 20, 1927	nplace (State or Foreign untry) MD
	Aaryland f ahow	or	Usual Residence of Decedent 10a. State 10b. County Maryland	Howard	10c. City, Town o		Ellicott City		10 m	10d. Inside City Limits 1 ☐ Yes 2 No
	with the ? 3a or 28a-	Funeral Director	10e. Street and Number 4646 Roundhill Ro	pad	1	10f. Zip Code	21043	11	0g. Citizen of What Cou U.S	untry? S.A.
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic event, the Medical Examinat must be notified at once.	þ	11. Marital Status 1 Never Married 25 Mar 3 Widowed 4 Divorced	M Yes Give	Ever in U.S. No 1945 1946	13. Was Decedent of If Yes, specify Cub		Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:	
Maryland 21215-0036	within 72 ho iene. r than "natur the Medical	Completed		nt's Education ist grade completed) College (1-4or to	(G	ecedent's Usual Occu live kind of work done fe. DO NOT use retire CI	pation during most of wo d) VII servant	rking	16b. Kind of Business/l National Se	ndustry ecurity Agency
land	uld be filed fental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle Willia	m Howard Rogers			18. Mother's Na	me (First, Middle, M Pat	Maiden Sumame) uline Barnes	
	and 2 shoulaith and Mills		19a. Informant's Name/Relation: Mr. Peter E. Ro		19b. M	ailing Address (Stree 307 Quail Hil	and Number or R. I Drive Brook	ural Route Number Keville, MD 20	City or Town, State, Zi 833	ip Code)
Baltimore,	iit. Pages 1 autiment of He ortant: If item njury or other.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (3	Specify)	cemetery.	isposition (Name of crematory or other play Cremation Se	rvices, Inc.	2/21/2004	20c. Location - City or T Sykesville	Fown, State e, Maryland
Ba	Depa fmpo any i		John lusten	la moos	35	22. Name a stack 3871	Punerat/Hon Old Columbi	ne, P.A. a Pike Ellicott	City, MD 21043	3
	Physician /Medical Examiner		23a Part 1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. HEA Due to (or as	a consequence of):	enter the mode of dyi		c or respiratory arre	est,	Approximate Interval Between Onset and Death
68760,	ertificate be executed ling physician and e as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of):					
.O. Box	death c e attend id for us	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		23d. Date of delive Month	very Day Year
rds, P	sign d be	by	Part II. Other significant condit	ons contributing to death b	out not resulting in th	e underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to s 2≸No 3 ☐ Pro	the cause of death?
Vital Records,	The law ate has b page 2 s	Completed						24a. Was ar autops perform Ves 2	y prior to co ned? death?	opsy findings available ompletion of cause of
Vita Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 192 Yes 2 □ No	Hospital:	2 EB/Outpo	atient 3□ DOA Ot	nar	ath (Check only one		7.1
ion of	Attending Physic death. sector: After this by the funeral di	I-	27. Manner of Death 1 Natural 5 Pendi	28a. Date of Inju	ry 28b. Tim y Year) Inju	e of 28c. Inju		28d. Describe ho Decease	mce 6 Other (Speci w injury occurred driving, to	irmed left,
Division	= = = =	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 286. Place of Inj		street, factory, office		28f. Location (Str	eet and Number or Rur , State) Little Pa	ral Route Number.
	To the Hospital c within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier Certifyi	ng Physicien: To the best Examiner: On the basis o	t examination and/o	eath occurred at the ti r investigation, in my	me, date and place opinion, death occi	e, and due to the ca urred at the time, da	use(s) and manner as	stated
	To the within 2	Med	29b. Signature and title/orcertifi	and manner st	u.U.	29c. Licen	se number	29	9d. Date signed (Month,	Day, Year)
	15		30. Name and address of person	who ted cause of c	leath (Item 23a) (Ty		C.M.E.	F	EBRUARY 18,	2004
	1		S.R.H	061AN			Street,	Baltimor	e, Maryland	1 21201
	Sta Regist		31. Date filed (Month, Day, Year		ar's Signature	Smile				

State of Maryland / Department of Health and Mental Hygiene 2001

ysician	1	I. Decedent's Name (First, Middle, L	Ralp.	h			2. Date of De Februa	ary Day 4,	2004	3. Time of Deat 0522 A
Medical caminer	A	a. Facility Name (If not institution, g	rive street and rumber)	4b. City, Town	n, or Location of De	ath	4c. Cou	inty of Death	1
	*	Johns Hoplins H			Balti					
neral ector		5. Social Security Number 6. 242-44-87% Juan Residence of Decedent	. Sex 7. A	ge (In yrs. last bir	Yrs. If Under 1 Yes Months Day		n. (Month, Da	rth ay, Year) 4-33	Cour	place (State or Forentry)
**	-	10a. State 10b. County		10c. City, Tow	n or Location				1	0d. Inside City Lin
incilling at	2	ma.		BAR	LTO.					1 1 Yes 2 □
be natified Director	1	Oe. Street and Number				9		10g. Citizen	of What Cour	ntry?
ust be		10e. Street and Number 2430 E. Li 11 Marital Status	g F Byeti	te Ave	2 21	1213		U	· 5A	?
examiner must		Marital Status Mever Married 2 Married Widowed 4 □ Divorced	Armed Forces	? No		uban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	8	Race - Americ Black, White, acify:	
		15. Decedent's	Education		Decedent's Usual Occ	cupation		16b. Kind of	f Business/Inc	dustry
r, the Madical Completed	2	(Specify only highest g Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	(Give kind of work dor life. DO NOT use reti	ired)		0	1. 11	1.46
Son Con	5	10th			TRUCK				ofh	NY
atic even	ן מ	17. Father's Name (First, Middle, La:	RALDH	,		18. Mother's N	ame (First, Middle	Maiden Sum	name)	
auma		19a. Inform unt's Name/Relationship	2 / 1/ -	-	. Mailing Address (Stre		/	A /	wn, State, Zip	Code) 21
her tr		Eileen Mit	chell F		2430 E	·LAFF	7		BAK	10 MG
or of	2	20a. Method of Disposition 1 Burial 2 Cremation 3	☐Removal from State	cemeter	f Disposition (Name of ry, crematory or other p		Date		on - City or To	own, State
ujury .	-	* 4 ☐ Donation * 5 ☐ Other (Spec	cify)	BA	WIEW CX	im. L-	20-04	DUNA	11/5,	Ma 21
any i		21. Signature of Funeral Service Lic			Wesley	A AVI	s SV. F	UNER	0/140	150 000
100		23a. Part1. Enter the disease, or co shock, or heart failud. List on	emplications that cause	ed the death. Do r		2001	711210			, ,,,,
cian lical liner		Immediate Cause (Final disease or condition resulting in death)	a. ATHER		TIC CARD	rying, such as cardi	ac or respiratory a	SEASY		Approximate Interval Between
ial-transit ial-transit	Lyalline	disease or condition	a. ATHER Due to (or as	OSCLERO	OTTC CARD, of):	rying, such as cardi	ac or respiratory a			Interval Betwee
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Iuneral director, page 2 should be detached for use as the burial-transit in the land of t	to be completed by right medical Examined	disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions CHROMC ETM 25. Was case referred to medical examiner? Name of Death Montage Name of Death Natural S Pending 2 Accident Newstigating Newstig	a. ATMER Due to (or as b. Due to (or as d. Due to (or as d. Due to (or as d. Pregnant a 9 Unknown s contributing to death I ANDLISM Hospital: 1 Inpati	s a consequence of a consequence of pregnancy 2 Fetal death at time of death but not resulting in	of): of): 3 Ectopic pregnar 5 Other (specify) In the underlying cause of the state of the	ncy 26. Place of D. Other: 4 \(\text{Nursing} \) Nursing	23e. Did 1 1 24a. Was auto, perific perific years	23d. I	Date of delivered Month Date of delivered Month Date of delivered Month Date of delivered Month Differed Month Date of delivered Month Date	Pry Day Year The cause of death ably 4 Minkings availing pletion of cause 2 No
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Registrar

			1 - For State Registrar	State of Ma	ryland /	Depa Cer	artment of H	lealth a Death	ınd Menta	al Hygier Reg.	ne 20	04	05891
ı	Physicia		1. Decedent's Name (First, Middle, Last Elaine M	attos	Robin	son				te of Death onth Druary	² 23 200	ear 14	3. Time of Death 3:00 PM
	/Medic Examin		4a. Fedlity Name (If not institution, give 282 Riverside Dr				4b. City, Town, or Pasa	dena	f Death		4c. County of Anne A		del
¥ -	Funeral Director		5. Social Security Number 6. Se 026 - 26 - 1945 Usual Residence of Decedent	x 7.Age □M 2⊠F	(In yrs. last I	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Da Sep	te of Birth onth, Day, Ye 14	1934	. Birthpf Count	ece (State or Foreign Ty) MA
	Ba-f show	ector	10a. State 10b. County Maryland Anne Ar	undel	10c. City, To	wn or Lo	Pasa	dena					0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	3a or 2	al Dire	10e. Street and Number 282 Riverside Dr	ive			10f. Zip Code	21122		10g.	Citizen of Wha		ry?
020	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If clem 27 is marked other than "natural", or flams 23a or 28a-f show of flem 27 is marked other than "natural", or there must be neithed at or other traumatic event, the Madical Examiner must be neithed at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		'	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Orig in, Mexican, Specify:	gin? (Specify Ye Puerto Rican,	es or No- etc.)	14. Race - Black, ' Specify:	White, e	n Indian, otc. White
0-612	ithin 72 ho ne. nan "natur Madical	Completed	15. Decedent's Edi (Specify only highest grad Efementary/Secondary (0-12)	ucation le completed) College (1-4or 5-		(Give	dent's Usual Occupi kind of work done of DO NOT use retired	during most ()	of working		. Kind of Busin		
7 011	I be filed w ntal Hygier od other th	Be	12 17. Father's Name (First, Middle, Last) Charles Mi	1 attos		Cr	yptanalys	18. Mother	r's Name <i>(First</i> ,	Middle, Maid	J.S. Go Hen Sumame) Liley	verr	ment
Maryie		To	19a. Informant's Name/Relationship (7) Thomas Robinson		15		ng Address (Street a	and Number	r or Rural Route	e Number, Cit	ry or Town, Sta		Code)
altillore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 It sny Injury or other tra		20a. Method of Disposition 1 Buriaf 2 XCremation 3 1 4 Donation 5 Other (Specify,		ceme	tery, crer	sition (Name of matory or other place	1	eb.Date 2		Location - Cit		_{vn, State} aryland
Dall	Departm Departm Importer sny Inju		21. Signature of Funeral Service Licens	4	ros	22	2. Name and Addres	ss of Facility	310				lome, P.A.
	Physician /Medical Examiner	Examiner	23a. Pert1/Enter the disease, or como shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	e of):	er the mode of dyin		cardiac or respi	ratory arrest,		1	Approximate Interval Between Onset and Death
,00700	ficate be executed physician and s the burial-transit	dical	that initiated events resulting in death) Last	Due to (or as a	consequenc	e of):							
.O. 50X C	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 morents? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of Live birth 2 4 Pregnant at 1 9 Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)				23d. Date o Month		y Day Year
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V 11.2	ysician: The is certificate director, pag	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatier	nt 2 ERV)	t 3 DOA Othe	nr.	of Death (Chec		0.770	(0.11)	
	는 문을	n: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	/ 28b	Time of Injury	28c. fnjun Work	4 1401		escribe how in		<i>ъресну)</i>	
DIVISION	tal or Atters after der el Directo	Certificatio	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, (Specify)	farm, str	eet, factory, office		28f. Lo.	cation (Street by or Town, St.	and Number o ate)	or Aural	Route Number,
	To the Hospital or Attending f within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edicai	(Check only 2 Medical Exem	rsician: To the best o iner: On the basis of and manner stat	examination a	ge, death and/or in	vestigation, in my or	oinion, death	place, and due h occurred at th	ne time, date a	and place, and	due to t	the cause(s)
	To To con	×	29b. Signature and title of certifier	an			29c. License		3		Date signed (M		1) 21061
مو	6			Man 30	5 H	(eqyT) (i	Print D	rive	Gler	Bu	mi e	M	1) 21061
	Sta	ite	31. Date filed (Month, Day, Year)	4 Magistra	r's Signature	A.	and s						

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Febryary 22 2004 2:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 14 1933 Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 □ M 2 🖾 F 218-28-6838 70 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ahow rment of Health and Mental Hygiene rtant: if flem 27 is marked other then "natural", or Itama 23a or 28a-1 ahov njury or other traumatic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Rol-Park Trailer Village 21108 USA Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No White Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Vernon L. Grimes Daisy В. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kevin Rver (son) 311 Burwood Road, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 25 20a. Method of Disposition 20c. Location - City or Town, State Department of I important: If Ite any injury or of 1 XBurial 2 Cremation 3 Removal from State Cedar Hill Cemetery Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 2004 permit 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** bea /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) P.O. Box 68760. attending pt IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 🗆 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b irector, page 2 sf 24a. Was an 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 💆 Other (Specify) HOS Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hoapital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54413 123 104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Baltomore 5. Hanover 3001 31. Date filed (Mont 32. Egistrar's Signature 2 5 2004 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Richard Stallings | February 2004 1720 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month), Day, Year) | Feb. 16,1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F 0klahoma Director 77 447-16-0044 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Middical Exercines must be notified at XX Yes 2 □ No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Randall Court 21401 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Named 1 □ Yes XX No Baltimore, Maryland 21215-0036 Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ Director CIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stanton Stallings 2 Margaret Gaines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joan V. Stallings (Wife) 11 Randall Court, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of the Important: If ite any injury or ott 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2/11/2004 Baltimore, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 10 LYa /Medical resulting in death) Due to (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cor Examiner The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No page 2 should be detached 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has autopsy performed? certificate 1 Yes 2 3 NO or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 res 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Bed Fell out of investigation 10:00 PM 1 ☐ Yes 2 ☐ No 01.29-04 death 2 Accident within 24 hours after death To the Funerel Director: 3 Suicide 4 Homicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 11 Kundal Hinnoldes To the Hospital neme 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jon B Lowe 3. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05897 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 21 SUITT **Physician** MAE 9:45 P M EVALINE 2004 BONNIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL CO. 342 COOL BREEZE COURT PASADENA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number Days Hours Min **Funeral** 1 ☐ M 2 🖫 F 84 Yrs Feb. 07 1920 | West Virginia 212**-**12-0478 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral', or items 23a or 28e-f show Examiner must be notified at 1 Yes 2 No Pasadena Directo Anne Arundel Co, Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21122 342 Cool Breeze Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2 No fYes, Give Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No 21215-0036 Specify: white þ 3 ♥ Widowed 4 Divorced Year or Dates: "natural", er than "nature". The Medical Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Weaver Cottrill Sarah Floyd Joseph 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Son) 343 Cool Breeze Court, Pasadena, Md. 21122 Daniel Cook 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit Pages 1 Department of H Important: if ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 02/27/04 Bridgeport, W. Va. Bridgeport Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee 3204 Mountain Road, Pasadena, Md. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eumo Physician /Medical Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed the attending physician and Due to (or as a consedur Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year jo 4☐Pregnant at time of death 5 ☐ Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **X**No 1 Yes 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home Hospital: 2X No Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Nature.
2 Accident 5 Pending investigation To the Hospital or Attend in within 24 hours after death To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) ame and address of person who completed cause of death (Item 23a) (Type) Print Verteransthighway Millers ville MD on 32. Registrar's Signature 31. Date filed (Month, Day, Year)

ORIGINAL

Registrar

			For Amend Item#25 Registrar 28a, 28fperM 1. Decedent's Name (First, Middle, La	EOG828 2/	25/04 EW	Ce	rtificate	of E	Death		2. Date of D	Reg.	No.	0 7	05898
-	Physici		Verna			Shau1	is				Feb.	1,	^D 2 004	Year	3:34 PM
	/Medic Examin		4a. Fecility Name (If not institution, give	e street and nu	mber)		4b. City, To						4c. County		
	LAGIIIII		Civista Medica	1 Cent	er				a, M				Char		
	Funeral		5. Social Security Number 6. S	ex □M 2XF	7. Age (In yrs. I		If Under 1 Months I	Year Days	If Under 2 Hours	Min.	8. Date of B	irth ley, Y	ear)	9. Birthp	lace (Stete or Foreign
	Director		211-20-2742 Usual Residence of Decedent	2.22.	90	Yrs.					Nov 13	3,	1913	Pen	nsylvania
	and w		10a. State 10b. County		10c. City	y, Town or L	ocation				·			1	0d. Inside City Limits
	Marylan -f show lied at	ţō	MD Char	les	No	ewburg	5								1 Pyes 2 No
	r 28a	irec	10e. Street and Number				10f. Zip C	ode				10g	. Citizen of W	hat Cour	itry?
	death with the Maryland rns 23a or 28a-f show Livest be notified at	Funeral Director	12429 Pinecrest I	ane			2066						U.S.A		
_	after death w	ner	11. Marital Status	Armed Fo		S. 13.	Was Deceder	nt of Hi y Cuba	spanic Orig n, Mexican,	in? (Spe Pu <i>e</i> rto	ecify Yes or N Rican, etc.)	10-		e - Americ k, Whit <i>e</i> ,	an Indian, etc.
2 %	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 □ Yes If Yes, Gi Year or D	ve		1 □ Yes 2]	No 🏂	Specify:				Specify	Whi	te
Pha 25-0036	within 72 hours after ene. then "netural", or the the Medical Exemitin	ed b	15. Decedent's B		74165.	16a. Dece	dent's Usual	Occupa	ition			16	b. Kind of Bu		
97 E	n n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)	1-4or 5+)	(Give	kind of work DO NOT use	done d retired	luring most)	of work	ing				
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Z 2	tally allow the tiled with and Mental Hygiene the marked other the aumatic event, the	Be	17. Father's Name (First, Middle, Las)							e (First, Middl	e, Ma	iden Sumam	θ)	
~ 5	should by and Menta	2	Charles Ringle:								Walker				0.41
1, 5			19a. Informant's Name/Relationship Marlene Lohr -	-	r						a <i>l Route Num</i> Newburg				Code)
7	Health Health tem 27		20a. Method of Disposition	Daugnee			osition (Name matory or oth			-	Date		c. Location ·		wn, State
3	Sozz		1XXBurial 2 Cremation 3 ('4 Donation 5 Other (Spec		State		matory or oth Co. Me		- 1	-9-	04	S	omerse	t. P	Δ
γ.	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Line	7.7	00		2. Name and	Addres	s of Facility	у			omerge		21
$\sqrt{0}$	Depa Impo	1	Men. Wo	blow	VVQ						al Home et Sc		rcat	РΔ	
47			23a. Part Enter the disease, or cor shock, or heart failure. List only	plications that	caused the death	h. Do not en	ter the mode	of dyin	g, such as	cardiac	or respiratory	arrest		***	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		One	un									Onset and Death
	/Medical		resulting in death)	Due to	(or as a conseq	uence of):		C							
	Examiner	_	Sequentially list conditions,	b	Ch	aze	ps	Lo							
	/Po tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consequ	derice of).	- 1	110	زسما	+	Cail	a.	A 4		
m	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consequence	uence of):				,	Cail				
. 032	- O 27 O	calE	(a C	ion	tre	w	al	ne	0	lisea	عد	e		
.03															
		hysician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		□Ectopic pre	gnancy					23d. Dat	e of delive	ory Day Year
0	deal	sicis	in the past 12 months? 1 ☐ Yes 2 🗗 No		nant at time of d		Other (spec						Mo	11.11	Day
	nat the	Phy	9 ☐ Unknown Part II. Other significant conditions	contributing to	death but not res	ulting in the	underlying ca	usa dive	on in Part I		23e Did	l tohac	co use conti	ibute to th	ne cause of death?
	w requires that the death cer been signed by the attendir should be detached for use	by	Him Hast	www.	to 18	CA T	Lan	130 g.v.	<i>e</i> .						ably 4 Unknown
3	require phonoic	Completed		0	-	-	11	10	C 7	- "	24a. Wa	is an	24h \	Vere auto	psy findings available
	has law	ig m	Sipopen re	men	1, 1	nier	~ 0		you	~	aut per	opsy forme	d? .	rior to co leath?	mpletion of cause of
	VIIAI NEC ician: The lav certilicate has rector, page 2.	e Co	25. Was case referred to medical	min	un				26 Place	of Deat	1 Yes		a No 1	Yes	2 No
	Vaicia rsicia	0	examiner?	Hospital:	Inpatient 2	ER/Outpatie	ent 3 DOA	Othe	ac		me 5 Re		e 6 □Oth	er (Specif	y)
1	9 Phy 9 Phy er this	i.	27. Manner of Death		of Injury onth, Day Year)	28b. Time		ic. Injury Work	at at		28d. Describe				
**	andin ath. or: Aft	atio	2 X Accident 5 ☐ Pending investigati	on 2/1/0			& AM		Yes 2 🔽	No	rell	in	bed	ro	em
	of Attending Physician: The law requires that the darm. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not 4 Homicide determine	build	e of Injury - At he ding, etc. (Specif	(y)	treet, factory,	office			City or T	own,	State)		Al Route Number,
(urs af				Hom					4 .1	12429 Pi				<u> </u>
	To the Hospital or Atlending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying F (Check only 2 Medicel Example)	miner: On the	ne best of my kno basis of examina nner stated.	wiedge, dea ition and/or i	nvestigation, i	i the tim in my o	pinion, dea	u place, th occur	and due to the red at the time	e, date	and place,	and due to	the cause(s)
	o the athin o the	Mec	29b. Signature and title of certifier	. 40-	and My	Tagas			e number			29d	. Date signed	(Month,	Day, Year)
	F 3 F ŏ		1000	Will	chel	the	nn E	0-0	00837	ZQ 3	>	5	tel -	2	2004
	NO		30. Name and address of person wh	completed cau	use of death (Item	п 23а) (Туре	, Print)							1	150
	50		Paul E. Pritch			10	nge A	ve,	LaP	lat	a,MD	20	646		
	St Regist	ate trar	31. Date filed (Month, Day, Year)	FEB 2 5	Registrar's Signal	aturo Alguna	J. St.	4	sell						

		1 - For State Registrar	State of Mar	-	epartment of F Certificate of		_		004	05899
Physi	cian	Decedent's Name (First, Middle, La IONA BURNS	SHEPHARD	1			2. Date of De Month	Day	Yeer 2004	3. Time of Death 9:15 P M
/Med Exam		4a. Fecility Name (If not institution, given			4b. City, Town, o	or Location of D		7	ty of Deeth	, , , , ,
LX	illiei	Si-ai Hospit	1 of Balti	more	Bal	timore			N/A	
Funera Directo		5. Social Security Number 6.	Sex 7. Age (In yrs. last birtho	Months Davs	If Under 24 F	fin. (Month, Da	th y, Year) 1905	Cour	place (State or Foreign htty) yland
P ×		Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town o	r Location				1	0d. Inside City Limits
iole; Inial yiallo Z I Z I 3-0000 ges 1 and 2 should be tiled within 72 hours after death with the Maryland if of Health and Mental Hygiene. If item 27 is marked other then "natural; or iteme 23e or 28e-f ehow or other traumatic event, I'm Medical Examinar must be notified at	ō	Maryland N/A								1 X Yes 2 □ No
the A	rect	10e. Street and Number		Dal	timore 10f. Zip Code			10g. Citizen of	What Cour	ntry?
3a or	0	8 Midvale Road				21210		II	.S.A.	•
deatl	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of H		(Specify Yes or No		ace - Americack, White,	
or ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No		1 ☐ Yes 2 ☑ No	Specify:	Jorio Tilodii, Gio.,	Spec	itv:	
hours at tural, or al Exam	d by	3 XWidowed 4 Divorced	Year or Dates:	16a D	ecedent's Usual Occup	ation			W	hite
in 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)	10	give kind of work done te. DO NOT use retired	during most of	working	16b. Kind of	Dusiness/inc	oustry
d with giene.	Eo	12 years	College (1-4or 5+)		Proprieto	or		Manu	factu	ring
ylaina Z I Z buld be tiled with Mental Hygiene. arked other the	BeC	17. Father's Name (First, Middle, Last)		-	18. Mother's I	Name (First, Middle,	Maiden Suma	ume)	
Mentite of stice	To	William	Burns			Eva	Ar	nspache	r	
2 sho and and is mu		19a. Informant's Name/Relationship			ailing Address (Street					
and 27 in 27 in the tru		Deborah S. Jenck			Midvale Roassposition (Neme of	ad Bal	timore, Ma	aryland 20c. Location		
Pages 1 nent of thant. If ite		1 ☐ Bunal 2 X Cremation 3	Removal from State	cem <i>etery</i> ,	crematory or other plac				,	
permit. Pages 1 and Department of Heal Important: if item 2 any injury or other		* 4 □Donation 5 □ Other (Special Signature of Funeral Service Lice		Green M	Ount Crema	tory 2	2-21-04	Baltin	nore,	Maryland
permit. Departn Imports any inju		NOI A	rane		22. Name and Addre Mitchell- 6500 Vork	Wiedefe	ld Funera Baltimore	1 Home	Inc.	1010
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused th	e death. Do not					Laud Z	Approximate Interval Between
Physician /Medica Examine	ıl 💮	Immediate Cause (Final disease or condition resulting in death)	a. Hypote Due to (or as a c	ns.ve	ASCVD					Onset and Death
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ate be ex hysicien the burial	<u>e</u>								Ī	
ficate ficate phys	edicai		_ d		_					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certiticate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 [4 Pregnant at time 9 Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	1			ate of delive	ory Day Year
v requires that the death been signed by the atte should be detached for	þ	Part II. Dther significant conditions	contributing to death but r	not resulting in th	e underlying cause giv	en in Part I.				ne cause of death? ably 4 Munknown
aw requires been si	Completed						24a. Was		Were autor	psy findings available
The la	Eo						autop perfo	rmed?	death?	npletion of cause of
Physician: The lavithis certificate has	Be	25. Was case referred to medical examiner?				26. Place of I	Death (Check only o			20110
Physic this ce	ToE	1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient		itient 3 DOA Oth	er: 4 🗆 Nursin	g Home 5 Resid	lence 6 □Ot	her (<i>Specif</i> y	<i>ı</i>)
ding Pl	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	eer) 28b. Tim Inju	ry Wor	k?	28d. Describe h	ow injury occu	rred	
ttend death ctor: / the	cat	2 Accident investigation 3 Suicide 6 Could not be	9 20a Place of Injune	- At home farm		Yes 2 □ No	28f Location /S	Street and Num	her or Rum	l Boute Number
at or A after after Direct	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify) 28f. Location (Street and Number or City or Town, State)							our or riora	Trigoto rvonicor,
To the Hospitat or Attending F within 24 hours after death. To the Funaral Director: Atter completely filled in by the funer	edical C									ated. the cause(s)
To th within To th	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signe	ed (Month, L	Dey, Year)
. /	/	5 M.O. D59062 February 19, 2004								
X		30. Name and address of person who		th (Item 23a) (Ty	pe, Print)		1	, , , , , , ,	/	1 2001
0		Chad J. Hanse	M.D.	2401 Wes	t Belvedere	Ave	Bultimore	MD	21215	-
	tate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	+ Belvedere					
Regis	_	FEB 2 5	2004	* (F //2						

State of Maryland / Department of Health and Mental Hygiene For Stete Registrar 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) Richard H. Stewart, Sr. 3. Time of Death 11:30 AM 2. Date of Death Mont Februar 23, 2004 **Physician** 4b. City, Town, or Location of Death Columbia 4c. County of Death Howard /Medical 4a. Facility Name (If not institution, give street and number) Examiner **Brighton Gardens Assisted Living** 8. Date of Birth (Month, Day, Year) April 8, 1901 Birthplace (State or Foreign Country)
 Virginia If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F Days Hours Min. 579-48-8094 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at Columbia 1 Yes 2 No Maryland Howard **Funeral Director** 10g. Citizen of What Country? U.S.A. 10f. Zip Code 10e. Street and Number 21045 with 0 7110 Minstrel Way or itams 23e death v 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: 14. Race - American Indian. 11. Marital Status Black, White, etc.
White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 3 ☐Widowed 4 ☐ Divorced "natural", Be Completed 16b. Kind of Business/Industry Photo Journalism 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use patired Photographer if Heelth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Symame, Ella Anthony 17. Father's Name (First, Middle, Last) Charles Frank Stewart ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 9757 Gudel Drive Ellicott City, Maryland 21042 Mr. Richard H Stewart, Jr. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Pages 1 ment of + ant: If ite ury or ot or other place) 02/28/2004 Brentwood, Maryland Fort Lincoln Cemetery permit. Page Department of Important: If eny injury or once. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name asiackerun Erdin Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 lean Murliller 1200535 and 1. Enter the diseas of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Irrediate Cause (Final disease or condition resulting in death) SPIRAT FAILURE Physician /Medical Due to (or as a consequence of) **Examiner** Most Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transil Ю STROKE Due to (or as a consequence of) Box 68760, attending physicien for use es the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yas 2 No 9 Unknown 9 Unknown 2 signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 2 0 No 1 🔲 Yes 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 42212LED 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes No Other (Specify) LIVING Certification: To 28a. Date of Injury (Month, Day Year) ieral Director: After the 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manper of Deal 5 Pending Injury Division Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by determined 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License numb 239178 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 30. NOTO PARTIES M.D. 10298 B. Bartimore Nation at Pike Ellicott City, MD 21042 32. Registrar's signature 31. Date filed (Month, Day, Year) State 25 200 Registrar

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RICHARD

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State of Maryland / Department of Health and Mental Hygiene , Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Ferrey SHIRLEY SCHWARTZMAN 22 1004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner UNION MEMORIAL HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JUNE 25, 1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** 1 □ M 2 🔽 F 214-18-2889 78 Yrs. SC Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits *ohe item 27 is marked other than "natural", or items 23a or 28a-f ehov other traumatic event, the Modical Examiner routs be nutified at 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5807 WESTERN RUN DRIVE, APT. C U.S.A. 21209 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2 X No 1 Never Married 2 Married Maryland 21215-0036 by 1 ☐ Yes 2 📉 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other eny injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SHAPIRO MILTON LILLIE ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STUART FINE / COUSIN 914 SORREL LANE - BRYNMAWR, PA 19010 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CHIZUK AMUNO 2/24/2004 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 ZMUTUM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsi tungal 20 days /Medical Due to (or as a consequence of): Examiner Chronic Reval 10 years Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo
9 Unknown for Month Day Year 5 Other (specify) P.O. I signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ cate has been signated by page 2 should b 3 ☐ Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performe Division of Vital 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending after death. Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital of within 24 hours of To the Funeral D. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) odel Hoberton m.o. AT 24389 46 06 February 22, 2004 10 J. Todd Hoberman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hosp fal menos (A) 40.00 201 un wees in 31. Date filed (Month Pers 32. Registrar's Signature State Registrar

				1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of l		Mental Hygie	200	4 05902
				1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Ye	3. Time of Death
		Physici /Medic Examin	al	Stanley 4a. Facility Name (If not institution, give	Alphonse re street and number)	S	chap 4b. City, Town,	or Location of Death	February	22, 200 4c. County of D	4 5:12 pm
				Harford Memorial	Hospital		Havre D	De Grace		Harfor	E
		Funeral		5. Social Security Number 6. 5		e (In yrs. last birthday		If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9.	Birthplace (State or Foreign Country)
	Н	Director		217-05-2604	IM ZUF	90 Yrs.			12/21/19	13 <u>M</u>	aryland
		and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
		Aaryl Sho	ō			141 7 77 m					1 ☐ Yes 2 🛣 No
		death with the Maryland ims 23a or 28e-1 show ir must be notified at	Directo	Maryland Baltimo	ore	Middle R	10f. Zip Code		10a	Citizen of What	Country?
		¥ 0 0	ᅙ								,
		leath	Funeral	827 Chester Road	12. Was Decedent	Ever in U.S. 13.	Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto		S. A.	merican Indian,
	"	fer of the control of	돌	1 ☐ Never Married 2 Married	Armed Forces?				Rican, etc.)	Black, V	/hite, etc.
	8	ours after death with the Marylan ral', or items 23a or 28e-1 show Examinar must be notified at	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify:	White
	50	be filed within 72 hours after ital Hyglene. Id other then "natural", or its event, the Medical Examina	Completed	15. Decedent's E (Specify only highest gr	ducation	(Giv	edent's Usual Occu	during most of work	ting 161	. Kind of Busine	ess/Industry
	21	ithin ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retire	ed)			
	21	Hygler ther th	ပ္ပံ	12		Stee	l Worker	40.14-11-1-11-1		ron Worl	KS
\	P		Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Mai	den Sumame)	
0)	Ya		၉	Joseph Schap				Catheri		gda	
70	altimore, Maryland 21215-0036	s 1 and 2 should t Health and Mer Item 27 is marke other treumatic		19a. Informant's Name/Relationship	•				ral Route Number, C		
7	6	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tree		Marie Antonette S 20a. Method of Disposition	Schap (Wife	20b. Place of Disp	Chester		dle River	Maryla Location - City	
0	ō	Pages nent of the int: If its iry or of		1 Burial 2 Cremation 3		cemetery, cre	matory`or other pla	ace) 2/	26		
S	Ħ	t. Partmen		' 4 □Donation 5 □ Other (Speci			sary Ceme		04 Ba	ltimore	Maryland
	Bal	permit. Departm Importa eny Inju		21. Signature of Funeral Service Lice	ns aa]	2. Name and Addre	ski Funera	l Home PA		
		EB = 9 G		23a. Part1. Enter the disease, or con	office ST					sex, Mai	cyland 21221
-				shock, or heart failure. List only	one cause a each lin	ne.	M .	mg, such as cardido	or respiratory arrest,		Interval Between Onset and Death
at the		Pnysician / /Medical	Ž į	disease or condition resulting in death)	a. 1911	gestive	Hear	VI (0	sure		
1	1	Examiner			Dua to (or as	(consequence of):	FRN	11.00			
tan			e	Sequentially list conditions, if any, leading to immediate	Due to (or as	c nsequence of	e l	wie			
54		uted ansit	티	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Antos	Wo School	otic (Condition ?	MALINE	\checkmark	
~ 1	Ć,	s be executed sician and burial-transit	Examine	resulting in death) Last	c. to (or as	a consequence of):		1 or maco	Mulh	ase	D. C. C. C. C. C. C. C. C. C. C. C. C. C.
J.	760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Ical		_ d				Cher		
Da	œ	tifical ig ph	Medi					-7.2271			
5	ŏ	leath certifica attending ph I for use as th	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		⊒Ectopic pregnanc	ev		23d. Date of	•
5		deat ed fo	SICIE	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□ Unknown		Other (specify)	,		Month	Day Year
	P.O. Box 6	that the de led by the a detached t	Physician/Med	9 ☐ Unknown			I II you got a little				
1		w requires that been signed is should be det	ρ	Part II. Other significant conditions	contributing to death b	ut not resulting in the	anderlying cause gr	iven in Part I.	1 ☐ Yes		o to the cause of death?
12	ord	requi	Completed						1 105		
7	ec	has b	nple						24a. Was an autopsy	24b. Were prior death	autopsy lindings available to completion of cause of
	<u>=</u>	ysician: The is certificate he director, page	Ç						performed 1 Yes 2		/es 2□ No
	Vita	Attending Physicien: Thir death. ector: Atter this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	_	Ott	han	h (Check only one)		
7	to	Phys this al dir	5	1 ☐ Yes 2 ☐ No 27. May er of Death	1 Linpatie		III JU DOA	4 Li Nursing no	ome 5 Residence		(pecify)
0	ū	tending Physieath. tor: After this the funeral dir	lo	1 Natural 5 □ Pending	28a. Date of Inju (Month, Da)	y Year) Zob. Tille (Wo	ork? Yes 2 \ No	Zou. Describe now	iquiy occurred	
CI	18	death death stor: / the	cat	2 Accident investigation 3 Suicide 6 Could not be	OB Diseasef Init	ury - At home, farm, s			28f. Location (Stree	t and Number o	Rural Route Number,
2/22/04	Division of Vital Records,	声특히드	Certification;	4 ☐ Homicide determined	building, etc	c. (Specity)	reot, ractory, omco	(1)	City or Town, S	tate)	riara riado ramba,
Ell		Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying P	hysician: To the best	of my knowledge, dea	th occurred at the ti	ime, date and place,	and due to the caus	e(s) and manner	as stated.
V	/	To the Hospital within 24 hours a To the Funeral Completely filled	edical	(Check only 2 Medical Exa- one)	miner: On the basis of and manner sta	examination and/or in	nvestigation, in my	opinion, death occur	red at the time, date	and place, and	due to the cause(s)
_		To the Ho within 24 I To the Fu completel	ž	29b. Signature and title of certifier		11/0	29c. Licens	se number	/ 29d.	Date signed (M	onth, Day, Year)
				* # 1/I	u	100		2066	(123	104
		di	3	30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	Printl	A 11	1000 1	£ 10.00	0.4.4.0
		/,		V. J. Leep	11) 06	7 Kevol	mon	8V. H	WIV ac	Tral	e NV
		Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	ji .	V			21018
		Registr	वा	FEB 2 5 2004	A The way say south	13	Long Hol				

State of Maryland / Department of Health and Mental Hygiene 05903 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 21,2004 Physician SIEGEL 3:00 P M EVA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE 8. Date of Birth (Month, Day, Year) APR.5,1905 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplece (State or Foreign Country)
 DISCET 8 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F RUSSIA 219-20-7941 98 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with U.S.A. 2500 W. BELVEDERE AVENUE #204 21215 Items 23a Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: if Items 72 is marked other than "natural, or theme 23, ury or other traumatic event, the Medical Experimentals. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Yes. Give Specify: 3 ☑ Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be YUCIRTZ SHULMAN MICHAEL LIEBE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 7111 PARK HEIGHTS AVENUE #312 - BALTIMORE, MD 21215 LENORE BLACK / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2/24/2004 BALTIMORE, MD BNAI ISRAEL CEMETERY! 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 7 Byens **Physician** disease or condition 1-vagressive catelorousalm disesse resulting in death) /Medical Due to (or as a consequence of): Examiner Alzways Due to (of as a consequence of): Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Authoritis 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 2 No 1 Yes Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3□ DOA Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury Division 5 Pending in 24 hours after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospitel within 24 hours a To the Funeral L filled Exertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2/23/04 D40371 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PrHarry BAUTIMANS, MO 21208 4000 at court RD Kaplan, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar FEB 2 5 2004

		1	For State Registrar	State of Ma	aryland / Dep	artment o	of Health of Deati	and M h	ental Hy	giene Reg. No. 20	04	05904
	Physicia	an	1. Decedent's Name (First, Middle, La	POWELL	THOM	2500			2. Date of Dea Month FEBRUA	Day	Year LOOL	3. Time of Death
3	/Medic Examin	and I	4a. Facility Name (If not institution, giv	e street and number) west Hospital C	enter	4b. City, To	wn, or Location	n of Death Randalls	stown	4c. County of	t Death Baltimo	ore
558	Funeral Director		5. Social Security Number 6. S 212-20-9821	Sex 7. Age	93 Yrs.	/) If Under 1 \ Months C	ear If Under Pays Hours	er 24 Hrs. Min.	8. Date of Birt (Month, Da NOV 27	. 1940	9. Birthpla	ace (State or Foreign Irginia
ight :	D		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10	Od. Inside City Limits
	e Maryl	Director	maryiane	imore			Woodlaw	/n 		10g. Citizen of W	hat Count	1 Yes 2 No
	3a or 24		10e. Street and Number 6814 Brompton Road			10f. Zip Co	212	207		TOG. CITIZEN OF VV	U.S.A.	· · · · · · · · · · · · · · · · · · ·
920	d within 72 hours after death with the Maryland Jiene. r than "natural", or itams 23a or 28a-f show the Madical Exans at must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🖄 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		. Was Deceder If Yes, specify			ecify Yes or No Rican, etc.)	14. Race Black Specify:	- America , White, e Bl	
Baltimore, Maryland 21215-0036	within 72 ho ene. than *natur he Medical I	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(Giv	edent's Usual (ve kind of work of DO NOT use	Occupation done during m retired) lome Mak	ost of worki :er	ng	16b. Kind of Bus	Home	
land 2	be filed Ital Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last	Powell			18. Mo	ther's Name	(First, Middle, Clar	Maiden Sumame y L D Powel)	
Mary	12 sho h and 7 is m		19a. Informant's Name/Relationship (Jeanette M. Austin	(Type, Print)	19b. Ma	iling Address (5 814 Brom	Street and Num pton Road	nber or Rura d Baltimo	al Route Numbe ore, Maryla	nd 21207	State, Zip	Code)
more,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci			itus Memo	rial Park	(Date 02/28/04		city or Tov timore	
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, oncome	I					al Home P altimore, M			Approximate
760,	by Secure of the property of t	cal Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of): a consequence of):	W.E						Onset and Death
O. Box 68	the d	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant al 9 ☐ Unknown	2 Fetal death	B⊟Ectopic preg Б⊟ Other (spec				23d. Date Mor	e of deliver	ry Day Year
٩	quires that the signed by and be detacted		Part II. Other significant conditions Acribe Steur		out not resulting in the	underlying cau	se given in Pa	n I.	23e. Did t	/		e cause of death? ably 4 Unknown
of Vital Records,	The law requir ate has been si page 2 should I	Completed by				····				osy p irmed? d	rior to con eath?	osy findings available inpletion of cause of
Vita	ysicien: The l is certificate ha director, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Outpat	ent 3□ DOA			h <i>(Check only c</i> ime 5 ☐ Resi	one) dence 6 □Othe	ır (Specify	·)
ion of	ttending Phys death. ctor: After this y the funeral di	ation; To	27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	iry 28b. Time	of 280	: Injury at Work? 1 \(\text{Yes} \) 2			how injury occurre		
Division	frer free n b	Certification;	3 Suicide 6 Could not determined	289. Place of in	jury - At home, farm, ic. (Specify)	street, factory,	office		28f. Location (. City or To	Street and Numbe vn. State)	er or Rura	l Route Number,
	To the Hospitel of within 24 hours a To the Funeral Completely filled in	Medical	29a. Certifier 1 Certifying P (Check only one)	thysician: To the best miner: On the basis of and manner st	of examination and/or	investigation, in	n my opinion, o	death occur	red at the time,	date and place, a	ind due to	the cause(s)
	To the within 2 To the comple	×	29b. Signature and title/of centifier	ries 1	no	1	License number			29d. Date signed FEBRU		123, 2004
	5		30. Name and addless of person who	CMPER	death (Item 23a) (Typ	Print) MI) -	-N	WH	4		
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 5	32. Re bist	rar's Signature	Sperte						

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dafe of Death Feb 17, 2004 **Physician** 4:40 Am. M Tyler Hazel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** N/A Wesley Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 15, 1914 Birthplace (State or Foreign Country)
 Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 R F Yrs. 89 Director 227-20-0427 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 23e-f show any injury or other traumatic event, the Medical France. 10b. County 10c. City, Town or Location 10a. Sfate 10d. Inside City Limits Pikesville 1 Yes 2 No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? U.S.A. 4711 Three Oaks Road 21208 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify. Black ģ Specify: 3 □XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Beauty Shop Elementary/Secondary (0-12) College (1-4or 5+) Beautician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luidar Moore Kit Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 2250 Willingboro, NJ 08046 Velma L. Watkins Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 □ Cremation 3 □ Removal from State 02/23/04 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) **New Cathedral Cemetery** 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Home P.A 1300 Futaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only-one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician ACU TE /Medical Due fo (or as a consequence of): Examiner DECUBITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed burial-transit MALNUTRATION and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Medical Certification; To Be Completed by Physiclan/Medical 23c. If yes, ourcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpafient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Dafe of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Natural 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify) determined 4 Homicide Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and fifle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-19425 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. - 2211 W-ROGURS AVE-BALTMORE, MD ROBERT E. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 5 2004 Registrar

		•	For State Registrar	State of Maryla	nd / Depa <i>Cer</i>	artment of H	ealth and I Death	Mental Hy	giene Reg. No.	2004	05906
W. S	er er		Decedent's Name (First, Middle, Las	t)				2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		Victor Robert	Turner				Februar		2004	1725 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	h	4c.	County of Deeth	
			Memorial	Hospital	lo at historia.	If Under 1 Year	If Under 24 Hrs.	9 Date of Ris	th.	1 albo	nplace (State or Foreign
	Funeral Director	-	210-10-0130	M 2 F 79	. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Sept 2	7, Year)	Cou	ryland
pue	* :		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
Maryl	or 28a-f show or notified at	jo	MD Caroli	ne P:	reston						1 ☐ Yes 2X No
the	28a-	rect	10e. Street and Number			10f. Zip Code			10g. Citi:	zen of What Co	untry?
h with	23a o	al D	24031 Friendship	Road		216	55			USA	
r deat	eme i	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or No to Rican, etc.))-	 Race - Amer Black, White 	
U Z I Z I 3-0000 filed within 72 hours after death with the Maryland	f Health and Mental hygiene. item 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, the Medical Examinat must be modified at	by Fu	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		1	Specify: W	hite
Hour	tural' al Ex		15. Decedent's Ec		16a. Dece	ient's Usual Occupa	ation		16b. Kii	nd of Business/I	
in 72	n n	Completed	(Specify only highest gra		(Give	kind of work done of DO NOT use retired	during most of wo	rking			,
d with	r tha	mo:	Elementary/Secondary (0-12)	0		accountan	ıt			financia	1
	ai Hyg	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle			
should be	Mental Hygiene. arked other than atic event, than	2	Victor Rober	t Turner				Belle			
2 sho	is m	0.3	19a. Informant's Name/Relationship (ng Address (Street a					
and 1	tealth		Carmen Turner/spo		Place of Dispo	31 Friend:	ship Roa	d Fresto		D 2165 cation - City or	
5 8g	i H ite		1 Burial 2 Cremation 3	Removal from State	cemetery, crer	natory or other plac	θ)			,	
Dallillor bermit. Pages	Department of Health a Important: If item 27 is any injury or other tragonce.		21. Signature Funeral Serv Licer K 9 na 1 + S	A		Name and Address ate Anato Itimore,		d, 655 W.	Ba1	timore	Street
8			Z3a, Part I Enter the disease, or com	plications that caused the de							Approximate
Die	iolom		shock or heart failure. List only Immediate Gause (Final	0							Interval Between Onset and Death
	ysician Medical		disease or condition resulting in death)	Due to (or as a conse	mmla equence of):	-					
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	===	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):						
cuted	trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
obe exe	hysician and the burial-transit		1950/(ing in death) Last	Due to (or as a conse	equence or):					1	
ecords, F.O. BOX 00/00, law requires that the death certificate be executed	physic the b	edical		_ d							
ath certifi	been signed by the attending pt should be detached for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		_			2	23d. Date of deli	very
Jeath Jeath	a atter	Physician/M	in the past 12 months?	1□Live birth 2□Fe 4□Pregnant at time of		Ectopic pregnancy Other (specify)				Month	Day Year
i he	by the	hys	9 Unknown	9□ Unknown							
S, T	gned e del	by P	Part II. Other significant conditions of	contributing to death but not re	esulting in the u	nderlying cause give	en in Part I.			_	the cause of death?
COLOS w requires	been sig should t		Hypertensic	W				1 🗆	Yes 2	□No 3□Pro	obably 4 Unknown
a v r	as be	ple						24a. Was auto	psy	prior to c	topsy findings available completion of cause of
1 g	page	Completed						1 ☐ Yes	omed? 2 No	death?	2 □ No
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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Vear **Physician** Mary L. Tavoso 10 Am Feb 19 2004 /Medical 4a Fecility Neme (If not institution, give street end number 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Lorien Nursing & Rehab.Center Howard Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 28 □ F Months 97 Director 145-30-6622 July 15,1906 New York Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Marylend nent of Heatth end Mental Hygiene.
int: If Item 27 is marked other than "naturel", or items 23s or 28s-f show 10c. City, Town or Location 10a. Stete 10d. Inside City Limits 10b. County ne 23a or 28a-f show must be notified at 1 ☐ Yes 2√2 No Funeral Director MD Columbia Howard 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 10476 Sternwheel Place 21044 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. I∏Yes 2∏XNo 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify Specify: white Completed by ¾□ Widowed 4 □ Divorced Yeer or Dates: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emanuel Boggiano Carmela Rivara 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Catherine M. kindbom/daughter 10476 Sternwheel Place, Columbia, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 George Washington Mem02/23/04 Paramus, N.J. injury 22. Name and Address of Fecility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 5555 Twin Knolls Rd.Columbia, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Alzheimer's dementia Immediate Cause (Final diseese or condition resulting in death) /Medical 10 years Examiner Due to (or es a consequence of Physician/Medical Examiner or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? funeral director, page 2 should be deteched 1 ☐ Yes 2 No 3 Probabty 4 Unknown Hypertension Be Completed by arthritis of knees 24b. Were autopsy findings 24a. Was an autopsy available prior to completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, Medical Certification: To this To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 X Naturel 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier Feb 20, 2004 M.D. D56531 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Columbia, mD 21044 4, 10780 Hickory Ridge Road, Harry MID. 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar

ORIGINAL

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Charlotte Chalone Taylor 1104 P^M February 22, 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 SF 84 Yrs. Maryland 218-07-3097 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State item 27 is marked other than "natural", or items 23a or 28e-f shov other traumatic event, the Medical Example at minut be notified at 1 ☐ Yes 2 ☑ No Edgewood Harford Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21040 USA 2307 Snow Road Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specity: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Bessie (NMN) Cerney Frank (NMN) Chalone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra Bredlow/Daughter 64 Forest Trail, Delta, PA 17314 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Department c Importent: If any in ury or * 4 □ Donation 5 □ Other (Specify) Bel Air Mem. Gardens 2-25-04 Bel Air, MD 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, MD 21009 21. Signature of Funeral Service Licensee mark 7 23a. Part1. Enter the dise se or bear lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-1 Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of deliven 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Vear in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown o 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Whiknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 1 Yes 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Ninpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifial erson who completed cause of death (Item 23a) (Type, Print) 7505 OSLBA DRIVE, TOWSON, MD21204 30. Name and address of person ·ANUSHA 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FFB 2 5 2004 Registrar

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			For State Registrar	State of Maryland		artment of F		nental Hy	giene Reg. No. 20	04 05910
	Physici /Medio Examin	an al	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give st FAST Point Nuv	reet and number)	,	R	r Location of Death	2. Date of De Month 7cb	Day 24, 20 4c. County o	Year 5-36 AM
e.	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. k	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th y, Year)	9. Birthplace (State or Foreign Country)
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show minportant: if Item 27 is marked other than "natural", or Items 23s or 28s-f show my injury or other traumatic svant, the Madical Examinating the notified at ance.	by Funeral Director	10a. State 10b. County MD BALTI 10e. Street and Number Neres	2. Was Decedent Ever in U.S. Armed Forces? 1 Was 2 No Armed Forces 20 No Armed 20 No Armed	13. \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	Nas Decedent of H	lispanic Origin? (Sp. An, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	- 14. Race	S. A American Indian, , White, etc. WhiTe
Maryland 2121	should be filed within 7 nd Mental Hygiene. : marked other than "r imatic svsnt, the Med	To Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 19a, Informant's Name/Relationship (Typ)	College (1-4or 5+)	life. L	OO NOT use retired MASのいみん	5)	e (First, Middle,	Maiden Sumame	, , , , , , , , , , , , , , , , , , , ,
Baltimore, Ma	permit. Pages 1 and 2 s Department of Health an Important: If Itam 27 Is i any injury or other traui ang.eg.		20a. Method of Disposition 1 Burial 2 Fremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	moval from State 20b. Pi	ace of Dispo emetery, crem	Hickosition (Name of natory or other place) Name and Address	sey 2/21	DR. P. Date IOY Ella Fu	BALTO.	MD.
,109	Physician /Medical Examiner the private transit	Ical Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. d.	Due to (or as a consequence)	Do not enter Dence of):	er the mode of dyir	\wedge	or respiratory ar	rest,	Approximate Interval Between
s, P.O. Box 68	Attending Physician: The law requires that the death certifica rdeath. cdeath. ector: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the standard of the second be detached for use as the standard of the second because the seco	by Physiclan/Med	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Dther significant conditions cont	-	death 3 ath 5 ath 5	1	en in Part I.	23e. Did to	Mont	oute to the cause of death?
Division of Vital Records,	ician: The law require certificate has been sig rector, page 2 should b	e Completed	Colon (an	icer ,	e m p	byser	26. Place of Deal	24a. Was autop perfor	an 24b. We pri med? de 1 C	B Probably 4 Dinknown ere autopsy findings available for to completion of cause of ath? Yes 20 No
sion of Vit	ending Physician: The lavasth. or: After this certificate has he funeral director, page 2	To B	examiner? 1	espital: 1 Inpatient 2 In 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 Nursing Ho	ome 5 Resid	dence 6 Other	
Divis	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	al Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	vledge, death	occurred at the tir	ne, date and place,	City or Tow	vn, State) cause(s) and man	or Rural Route Number, ner as stated.
)	To the He within 24 To the Fu Completely	Medical	29b. Signature and title of certifier	er: On the basis of examinate and manner stated.	ion and/or inv	restigation, in my o	pinion, death occur	red at the time,	date and place, an	(Month, Day, Year) -4, 2=9 (Lg 2(224)
	Sta Registr		30. Name and address of person who con Mg (+ LCL) 31. Date filed (Mor B db), Dead (1) 4	npleted cause of death (Item	23a) (Type,	Print) 40 Ecs	tern A	ve ,	Bolt	rig 21224

		•	1 - Stote Amend ITem #18	State of Marylan Per fn 6828	d Depar Cert	tment of 14 tas ificate of	Health and f Death			+ 05911
	Divt-1		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		ARVID IVES VINCENT					02-	20-04	12:30 PM
4	Examin		4a. Facility Name (If not institution, give st			4b. City, Town	, or Location of Dea	ith	4c. County of Dea	
			Franklin Square Hos	spital Center		Koseda			Baltime	
A	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. 90	last birthday) Yrs.	If Under 1 Year Months Day		. (Month, Day,	Year) C	rthplace (State or Foreign country)
21	Director		185~09~0715	90	115.			Nov. 11,	1913 Fr	rance
	and w		10a. State 10b. County	10c. Cit	y, Town or Loca	ation				10d. Inside City Limits
	Mary	ō	Maryland Baltimore	C	hase					1 ☐ Yes 2 ☐XNo
	28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	3a or		12829 Eastern Avenu	ie		2102	27		USA	
	ms 2	Funeral		2. Was Decedent Ever in U	.S. 13. W	as Decedent of	Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	
9	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No If Yes, Give		Tes, specify Co		itto moan, etc.)		
8	72 hours after death with the Maryland natural; or items 23a or 28a-f ahow deal Examinet must bu motified at	d by	3√ Widowed 4 □ Divorced	Year or Dates:						/hite
21215-0036	72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give ki	int's Usual Occ ind of work don	e during most of w	orking 1	6b. Kind of Business	s/Industry
12	han han	d E	Elementary/Secondary (0-12)	College (1-4or 5+)		ace Eng			erospace	Industry
2	iled v tygie ther t	ပိ	12 yrs. 6	yrs.	Verosh	ace Life		ame (First, Middle, M		andoos y
Maryland	ntal hed od od	Be	Arvid Ives Vincent				-Unknow		ance Ives	,
Ž	hould d Me mark matic	ဥ	19a, Informant's Name/Relationship (Typ	e. Print)	19b. Mailing	Address (Stre	0	Rural Route Number,		
Z Z	d2 s ith ar 27 is treu		Calvert Gray	•	12829	Easter	rn Avenue	Baltimore	e, Md. 210)27
9	s 1 and 2 of Health a item 27 is other tree	1 3	20a. Method of Disposition		Place of Disposi cemetery, crema	tion (Name of	lacel	Date 2	0c. Location - City o	r Town, State
0	ages ent of nt: N i		YBurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	rkwood			4~04 Ba	altimore,	Maryland
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f ahow any injury or other treumatic event, the Madical Examinet must be notified at ODCe.		21. Sin aure of Funeral Service License		22.	Name and Add	Iress of Facility	7401	Belair R	
B	Department Department		Mostro the cont	a Chamer	L	assahn	Funeral	^{Home} Balt	imore, Md	. 21236
	· 8		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the dear	th. Do not enter	the mode of d	ying, such as cardi	ac or respiratory arre	st,	Approximate Interval Between
	Physician	0	Immediate Cause (Final	R	at 1	wit				Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consec	uence it).	11 1 70				
疆	Examiner		Sequentially list conditions b.	Intrac	rebral	Blead				3days
		Iner	if any, leading to immediate	Due to (or as a consec	quence of):					
	nd rans	Exam	Cause (Disease or injury that initiated events c.							
Ő,	e exe	Ě	resulting in death) Last	Due to (or as a consec	quence of):					
8760,	cate be executed physician and the burial-transit	dlcai	d.							
9	eath certific attending p I for use as I	0	IF FEMALE:	ic. If yes, outcome of pregn	ancy				22d Date of de	Nine .
Вох	the death certift y the attending iched for use as	Physician/M	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 🗆 E	Ectopic pregnar Other <i>(specify)</i>			23d. Date of de Month	Day Year
o.	the s	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	, oaiii 5	Ottler (apachy)				
٩	that the de led by the a detached i		Part II. Other significant conditions conf	inbuting to death but not res	sulting in the und	derlying cause	given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ds,	sign d be	d by						1 🗆 Yes	2 Ø No 3 ☐ F	Probably 4 Unknown
Ö	w requir been si should	ete						24a. Was an	24b, Were a	utopsy findings available
Vital Records,	e la has	Completed						autopsy perform	prior to ed? death?	completion of cause of
a		e Co	25. Was case referred to medical				26 Place of D	1 ☐ Yes 2 eath (Check only one	No 1 ☐ Ye	s 2 No
₹		o Be	examiner?	ospital: 1 👸 Inpatient 2] ER/Outpatient	3 DOA)ther	Home 5 ☐ Resider		ecify)
of		\vdash	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. in		28d. Describe how		
ion	th. : After s funer	tlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Yes 2 No			
Division	or Attendi after death. Director: A in by the fu	iffe	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci		et, factory, offic	:0	28f. Location (Stre City or Town,	et and Number or F	Rural Route Number,
Ö	al or A s after ni Direct nd in by	Certification:	4 - Homeide	banding, atc. (Special	97			ony or voice,	J. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	
	Hospit 4 hour Funer ely fille		(Check only 2 Medical Examin	ician: To the best of my kn er: On the basis of examin						
	To the Hospital or Attending wit in 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Lice	nse number	29	d. Date signed (Mor	oth, Day, Year)
	F 3 F 8	,	BELLON	V		1	2/1104		2/20/0	74
7	4		30. Name and address of person who col	npleted cause of death (Ite	m 23a) (Type, P	r nt)	00.7	310.5	, , , , , , , , , , , , , , , , , , ,	
	-0		Dr Ard Sheikh 9	MAG	£	Done	Saltin	re 101	1237	
	Sta	ate	31. Date filed Mong Doy, Bar 2004	22. Registrar's Sign	ature	46		7		
	Regist		י היי א ט הטען	RACIN HAR D	ana.	85 F.				

			1 - For Stete Registrar	State of Maryland			of Health and of Death		giene leg. No. 201	14 0591
	Physic /Medi		Decedent's Name (First, Middle, Last RICHARD	•	LGAR	IS		2. Date of Dea Feb. 1	8 Day 200 4ea	3. Time of Death 6:45 рм
1	Exami		4a Facility Name (If not institution, give Univ. of Maryl	and Medical		Bal	m, or Location of Deal timore		4c. County of De	
	Funeral Director		5. Social Security Number 214-40-7024 6. Se 1%	x 7. Age (<i>In yrs. las</i> ☐ M 2☐ F 60		If Under 1 Your Months Da	ear If Under 24 Hrs ays Hours Min.		, Year)	irthplace (State or Foreign Country) ryland
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23e or 28e-f ahow ant, the Medical Examina must be indiffied ut	Director	10a. State 10b. County	undel Co.	Town or Lo	cation en Burr			Og. Citizen of What (10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	s 23a or	rai Dii	367 Taylor Ave.			21	1060		U.S.A.	
980	ours after de ral', or Item Evander	d by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 17 Yes 2 No If Yes, Give Year or Dates:	J		of Hispanic Origin? (S Cuban, Mexican, Puer No <i>Specify:</i>	pecify Yes or No- to Rican, etc.)	14. Race - An Black, Wi Specify: W	•
Baltimore, Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hyglene. Item 27 is marked other then "natural", or Items 23e or 28e-1 ahove other traumatic event, the Medical Evandure must be codified at	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)		(Give life. L	lent's Usual Ockind of work do NOT use re . Chef	one during most of wo	rking	16b. Kind of Busines Mangia	s/Industry
land	2 should be filed withir and Mental Hygiene. Is markad other than aumatic evant, the Me	To Be C	17. Father's Name (First, Middle, Last) John	Vulgaris			18. Mother's Nar Helen	ne (First, Middle, I		ose
, Mary	t and 2 should the Health and Menter tem 27 is marked other traumatics	200	19a. Informant's Name/Relationship (7) Melissa Seabolt	_{грө, Print)} (Daughter)	19b. Mailin 3001	g Address (Str # G Se	eabury Road	na/Route Number 1, Baltin	; City or Town, State,	Zip Code) 21225
more	Page lent c int: If ry or		20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Demoval from State COT	netery, cren	sition (Name or natory or other en Memo	p _{p(ace)} prial Pk.02		20c. Location - City o	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licens	& bline	22	Name and 10 32	Cully-Pol 204 Mounta	niak Fur in Road,	neral Home Pasadena,	P.A. Md. 21122
ناح	Pnysician /Medical	182	23a Part Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Lung C	ance		dying, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Examiner	e	Sequentially list conditions	Due to (or as a consequence. Due to (or as a consequence).						
,8760,	cate be executed by sician and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a consequen	nce of):					
O.	death certifii e attending p id for use as	Physician/Medic	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat	eath 3 🗌	Ectopic pregna Other (specify			23d. Date of do Month	alivery Day Year
S, P	w requires that the been signed by th should be detache	ρ	Part II. Other significant conditions con	ntributing to death but not resulti	ng in the un	derlying cause	given in Part I.			to the cause of death?
E	The law ate has t page 2 s	Completed						24a. Was ar autops perform 1 ☐ Yes 2	y prior to	utopsy findings available completion of cause of s 2 2 No
ion of Vit	Attending Physician: If death. actor: After this certific by the funeral director,	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death XNatural 5 Pending investigation	lospital: 1 Minpatient 2 EF 28a. Date of Injury (Month, Day Year)	VOutpatient Bb. Time of Injury	28c. lr	Other	th (Check only one ome 5 Reside 28d. Describe ho	nce 6 □Other (Spe	acify)
5	in Direct	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, offic	се	28f. Location (Str City or Town	reet and Number or F , State)	tural Route Number,
	na Hospital 124 hours a 18 Funeral 19tely filled	ledical (29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the estigation, in m	a time, date and place by opinion, death occur	and due to the ca red at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To tha P within 2- To the P complete	Me	29b. Signature and title of certifier	m. M.D.		P1	nse number . 7681		eb。23,	
	112		30. Name and address of person who co Geoffrey D. Moo	rer, MD 22 S	. Gr	eene S	St, Balti	more, M	aryland	21201
	Sta Registr	_	31. Date filed (Month, Day, Year) FEB 2 5 200	320 Registrar's Signatur	120	and I				

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:25 AM Mollie Vaughan 4a Facility Name (If not institution, give street and number) 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Street Biddle Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Qountry) **Funeral** 1 □ M 2 1 F 64 Director a. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at Baltimore 1 Yes 2 No Director 10f. Zip Code 10e. 10g. Citizen of What Country? 10 or Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. If item 27 is marked other than "natural" or liement injury or other trainmant. Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Blac 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry observed in Substitution (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Care Provider grade Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Be proaddus 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) E. Biddle Street Baltimore, Md. 21202 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Firt Mt. Olive Church Cen. 2 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Sonature of Funeral Service Licenses 22. Name and Address of Facility Fasi North Ave 1101 Nation 23a. Per L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final di Jeas in or condition resulting in death) Physician nu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to fr as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 the attending physicien Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed certificate 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 Inpatient Medical Certification; To 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funeral Diractor: After this filled in by the tuneral 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 346 80 ss of one on 33rd St. #136 Baltime Md. 21217 Kando 31. Date filed (Month, Day, Year) FEB 2 5 2004 3. Registrar's Signature State Registrar

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05914 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle:) Last) **Physician** /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 01 um If Linder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul 21, 1955 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2√□ F Director 218-60-9455 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Funeral Director N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21223 1932 Lemmon Street 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Black Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Home College (1-4or 5+) Elementary/Secondary (0-12) Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie Wilkes Robert Lomack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1932 Lemmon Street Baltimore, Maryland 21223 Robert Williams 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 □ Burial 2 □ Cremation 3 □ Removal from State Landsdown, Maryland 02/23/04 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner or Attending Physician: The law requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 90 Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 NO 1 TYPS 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funerel Director: After this 28c. Injury et Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injun Natural 5 Pending 1 Tyes 2 No investigation 2 Accident completaly filled in by tha 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar

524

5

			1- For State of Mar	yland / Depa	artment of Health and rtificate of Death	Mental Hygie	•	05915
	Physic /Med	ical	1. Decedent's Name (First, Middle, Last) Bernard S. Woodson Jr.			2. Date of Death Month February	Day Yeer 23 ZOOY	3. Time of Death 6:46pm
	Exami		4a. Facility Name (If not institution, give street and number) S. Z. V. A. T. 5. Social Security Number 6. Sex 7. Age (i	n yrs. last birthday)	4b. City, Town, or Location of Dea	th e	4c. County of Deeth	(2)
	Funeral Director		217-62-1790 1 M 2 □ F 49 Usual Residence of Decedent	Vea	Months Days Hours Min		ear) 9. Birth Cour 4 Mary 1	elece (State or Foreign etry) and
	he Marylar 8a-f show	Director	Maryland	Oc. City, Town or Lo Baltimor	e		1	0d. Inside City Limits 1 Y Yes 2 □ No
	with ti	Dir	10e. Street and Number 3020 Grantley Avenue		10f. Zip Code		Citizen of What Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be multiled at 2008.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Pes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1	21215 Was Decedent of Hispanic Origin? (sf Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☼ No Specify:		S.A. 14. Race - Americ Black, White, Specify: Bla	etc.
Maryland 21215-0036	ithin 72 ho ne. nen "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking 16b	. Kind of Business/Ind	dustry
and 21	be filed wat that Hygier the other the event, the	Be Cor	11 17. Father's Name (First, Middle, Last)	Mec		me (First, Middle, Maid	itomobile den Sumame)	
3	should nd Mer marke matic	2	Bernard S. Woodson Sr. 19a. Informant's Name/Relationship (Type, Print)	19b Mailin	Viola S		hung Tourn State Tim	Codel
ore, Ma	ies 1 and 2 s of Health ar if itam 27 is or other trau		Diane Woodson / Wife	617 L	vndhurst Street.			
Baltimore,	permit. Pag Department Important: any injury c		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	22	ematory Inc. 02/2 Name and Address of FacilityThe	Derrick C	. Jones F	/H, P.A.
3	Physician /Medical Examiner		23a. Part . Enter the disease or complications that caused the shock, or plean failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a condition or substitution of the condition of the cond	c ARd	11 Park Hgts. Ave er the mode of dying, such as cardial AL INFAR	or respiratory arrest,	ore, Maryla	Approximate Interval Between Onset and Death
8760,		Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a condition of the c					
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-Itansi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	y Day Year
rds, P	quires that n signed b	b	Part II. Dther significant conditions contributing to death but not be the significant conditions contributing to death but not be significant.			23e. Did tobacc	o use contribute to the	
Division of Vital Records,	The law requir sate has been si page 2 should I	Completed	TYPE B AURTIC	Disse	ction	24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			th (Check only one)		
on of	tending Physician: leath. tor: After this certific the funeral director,	tlon; To	27. Manner of Death 1 Natural 5 Pending 2 Accident 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 Propertient 28b. Time of Injury	3 DOA Cther: 4 Nursing H 28c. Injury at Work? M 1 Yes 2 No	ome 5 Residence 28d. Describe how in		
Divisi		Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (S	At home, farm, stre		28f. Location (Street: City or Town, Sta	and Number or Rural ate)	Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of m 2 Medicel Exeminer: On the basis of examiner and manner stated.	y knowledge, death mination and/or inve	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the cause(rred at the time, date a	(s) and manner as sta nd place, and due to	ted. he cause(s)
)	S Com	Σ	29b. Signature and title pre-mitter Physical Ph	EIAN	29c. License number DOOSYS		OFUGRY	ay, Year) 23,2004
	7		30. Name and address of person who completed cause of death	1045 2			imove, m	0 51512
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	H Small		,	

DHMH 17 Rev 1/2001

Woodson IR, Bernard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20004

For Amend Items 9,10e,11,12,16ab,18,19ab,20abc,22 per FH,6829,03/16/04dhb

Red. No.

Red. No. 2. Date of Death 3. Time of Death 18,2004

1. Decedent's Name (First, Middle, Last) **Physician** Februari Mary Wright /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hospital Genera Maniland 8. Date of Birth
June 24, Year) 925 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🛣 F 78 228-26-2238 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28e-f show 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. I are 11 is marked other than "natural", or Items 23a or 28e-1 show ther fraunatic event, it a Madical Examination to confine MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Regester 812 Register Avenue 21239 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 1 X Never Married 2 Married ☐Yes 2 No unk 1 ☐ Yes 2K No If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, Maryland 21215-0 unk Elementary/Secondary (0-12) unk College (1-4or 5+) Waitress Restaurant unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Unk -unk Be Gladys E. Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1225 D-annux Road, Parkville, MD 21234 ca of Disposition (Name of Date 200 Md General Hospital Barbara Mercer/Friend permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 Is any injury or other trau <u>once</u>. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State in state Metro Crematory Inc. 3/11/04 Baltimore, MD * 4 ☐ Donation 5 M Other (Specify) 22 Name and Address of Facility Cremation Socity of MD, 299 Frederick Rd. State Anatomy Board 655 W. Raltimore Street 21. Signature of Funeral Service Licensee ROH Ld S. Wade 21201 Balto, MD 21228 Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coli Escherichia **Physician** /Medical Due to (or as a consequence of): Examiner Shoc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last enydration burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknown <u>م</u> Records,

23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death?

4030

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

TX Yes 2 □ No

_unk

Virginia

USA

Specify: white

14. Race - American Indian, Black, White, etc.

4c. County of Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Probably 4 Unknown 1 ☐ Yes 2 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗹 No

25. Was case referred to medical examiner? 1 🗌 Yes 2 No 27. Manger of Death

1 Natural

2 Accident

3 Suicide

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

and manner stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 28b. Time of 28c. Injury at Work? М

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 4 Homicide 29a. Certifier (Check only one)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

2/18/04

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Car

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 827

Buttons N-60

State Registrar

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Completed

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Certification: To

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within 24 hours after death. To the Funeral Director: A

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Division of Vital

were the 31. Date filed (Month, Day, Year) FEB 2 5 2004

Registrar's Signature

			1 - For State Registrar	State of Maryland	/ Depa	artment of Hertificate of D	ealth and M Death	ental Hygi	ene 200	14 0591
I	Physic		1. Decedent's Name (First, Middle, Last HELEN R.	*	/ / /	AMS		2. Date of Death Month Februar	1	
*	/Medi Examii Funeral Director		4a. Facility Name (If not institution, give HARBOR HOS 5. Social Security Number 217-22-2400	street and number)		4b. City, Town, or I BALTIA	ocation of Death	8. Date of Birth (Month, Day, Dec. 12	4c. County of Do	
	Maryland	tor	Usuel Residence of Decedent 10a. State 10b. County Md. Anne Aru		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28s	Funeral Director	10e. Street and Number 7900 Benesch Cir	cle		10f. Zip Code 2106	51	10	g. Citizen of What	Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-1 show mith injury or other traumatic event, it is Model Examilia to Intermite the Intelligent and DRG.	b	11. Marital Status 1 Never Married 2 Married 3 Nover 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2☐ No If Yes, Give^ Year or Dates:		Was Decedent of His f Yes, specify Cuban I ☐ Yes 2 X No	panic Origin? (Spe , Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ar Black, W Specify: W	
21215-0036	within 72 ho iene. r than "natur Ite Mudical	Completed	15. Decedent's Edu (Specify only highest grad		(Give	lent's Usual Occupat kind of work done du OO NOT use retired)	ion ring most of workin	ng 1	6b. Kind of Busines	
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It e M.	To Be C	17. Father's Name (First, Middle, Last) Arthur Sene				8. Mother's Name Bernadett	e		unknown
	Tand 2 sh Health and tem 27 Is m		19a. Informant's Name/Relationship (T) Paul A. Williams 20a. Method of Discosition	Sr. (Son)	4119	g Address (Street an Audrey Av	ve. Balti	more, Mo	1. 21225	
Baltimore,	permit. Pages 'Department of Himportent: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	Mead	owrid	sition (Name of patory or other place)	ck 02/25	/04 1	oc. Location - City of	Md
g	Departr Departr Importe any inji		23a. Partf. Enter the disease, or compl	Ellin		Name and Address McCully 3204 Mc	ountain R	oad, Pas	sadena. M	.A. d. 21122
<i>-</i>	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequer Due to (or as a consequer Due to (or as a consequer	nce of):					Interval Between Onset and Death 1 week
68/60,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	nce of):					
DOX 0	de th certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetel de 4 Pregnant at time of deatl	ath 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	signed d be de	by	Part II. Other significant conditions cor	ntributing to death but not resulting	ng in the un	derlying cause given	in Part I.			to the cause of death? Probably 4 □Unknown
ai necc		Completed						24a. Was an autopsy performe	24b. Were a prior to death?	
DIVISION OF VITAL RECORDS,	Attending Physicien: I r death. ector: Afler this certificat by the funeral director, pc	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation		/Outpatient b. Time of Injury	3□ DOA Other: 28c. Injury a Work?			ce 6 Other (Sp	ecify)
UNIS	spitel or Attency on a strancy on a strancy on the strancy of tilled in by the the the strancy of the strancy o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office	28	Bf. Location (Stree City or Town,	et and Number or F State)	Rural Route Number,
	lo the Hospitei or Attenwithin 24 hours after deat To tha Funerel Director: completely filled in by the	Medical	one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	and/or inv	estigation, in my opin	ion, death occurred	d at the time, date	and place, and du	e to the cause(s)
)	है ५ हैं ≗	-	29b. Signature and title of certifier	M.D. mpleted cause of death (Item 23 M.D HARBOR HO 33 Registrar's Signature		RES C	umber 200	29d Fe	Bate signed (Mon	11, Day, Year) 21, 2004
	Sta		30. Name and address of person who co GOR DOROKHINE, I 31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23 M.D. HARBOR HO 32 Registrar's Signature	Spita	(P, 3001 So	outh Hano	ver St. 1	Baltimos	e, MD, 2122
	Registr	ar	31. Date filed (Month, Day, Year) FEB 2 5 200	A State St	Spa					

		_	For State Registrar	State of Mar		ertificate of			giene Reg. No. 200	+ 05918
	hysicia	in	Decedent's Name (First, Middle, La. Susanna M. Wade					2. Date of De Month Februa:	Day Year	3. Time of Death 6:18 PM
	/Medic Examin	aı er	4a. Facility Name (If not institution, give Kensington Nursing	street and number)	itation	4b. City, Town, o	or Location of Deat		4c. County of Dea	
	ineral rector		5. Social Security Number 6. S		In yrs. last birthday		If Under 24 Hrs		th 9. Bir	y thplace (State or Foreign ountry) t Virginia
ryland	thow 1 at		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or I	ocation.				10d. Inside City Limits 1 ☐ Yes 2X No
th the Ma	or 28a-f	Funeral Directo	Maryland Montgome 10e. Street and Number	ery 1	Kensingto	10f. Zip Code			10g. Citizen of What C	
₹ .×	23a	le l	3000 McComas Aven	16		20895			United Stat	
d Z1Z15-0U36 filled within 72 hours after death with the Maryland Hygiene.	r than "natural", or items 23a or 28a-f show the Mudical Exertmet must be coulded at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Even Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13	. Was Decedent of I If Yes, specify Cub		Specify Yes or No to Rican, etc.)	Specific	
Z1Z15-UU36 id within 72 hours af giene.	"natura edical E	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)	(Giv	edent's Usual Occur re kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Business	
withi ene.	than to M	mc	Elementary/Secondary (0-12)	College (1-4or 5+)	Homer	naker			Own Home	
Hyge	othe /ent,	a l	17. Father's Name (First, Middle, Last,)			18. Mother's Na	me (First, Middle	. Maiden Sumame)	
Maryland d 2 should be file th and Mental Hy	D 9	To B	Isaac Martin				Bertha I	Davidson		
2 sho	S 50		19a. Informant's Name/Relationship (Type, Print)	1.				er, City or Town, State,	
	am 27 ther to		Alexander Waddell 20a, Method of Disposition	/Son	4620 20b. Place of Disp		Orive, Ch	nevy Chas	se, MD 2081	
Baltimore, Dermit. Pages 1 ar Department of Hea			1 X Burial 2 ☐ Cremation 3 ☐		cemetery, cr	ematory`or other pla	1			
III. P.	Important: il any injury o once.		*4 ☐ Donation 5 ☐ Other (Specifical Service Liber)			22. Name and Addre		9, 2004	Bridgeport	, w.v
Deg Ped	any ir		Manage L	. Losso	110	Hlen Fun 215 East 1	eral Home Main St.,	e Bridge	port, WV 26	330
	sician edical		23a. Part Fenter the sease of comshock, or head ailure lidst only Immediate Caus Final disease or condition resulting in death)	a. Pneumoni	a	nter the mode of dyi	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
	miner			Due to (or as a c	consequence of):					
. Box 68760, death certificate be executed	hysiclan and the burial-transit	ical Examiner	Sequentially list conditions if any, leading to immediate cause Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
687	physis sthe			d						
.O. Box (ned by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2: 4 Pregnant at tir 9 Unknown	Fetel death 3	☐Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
rds, P.	50 8	þ	Part II. Other significant conditions of Progressive Alzhe			underlying cause gr	ven in Part I.		robacco use contribute t Yes 2 ☐ No 3 ☐ P	o the cause of death?
Division of Vital Records, P.O or Attending Physician: The law requires that the after death.	ate has been si page 2 should t	Completed							ormed? death?	utopsy findings available completion of cause of
	is certificate ha	Be C	25. Was case referred to medical examiner?	24.00				ath (Check only o		
of V	this ce ral dire	ို	1 ☐ Yes 2 ☐XNo		2 ER/Outpati				dence 6 Other (Spe	ecify)
Vision of Vita Attending Physician: r death.	After	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1	ryat rk?]Yes 2 □ No		how injury occurred	
DIVI tal or Att	Funeral Director: tely filled in by the	Certifi	3 Suicide 6 Could not be determined			street, factory, office		City or To	Street and Number or R wn, State)	urai Houte Number.
		edicai	(Check only 2 Medical Example)	nysician: To the best of miner: On the basis of e and manner state	xamination and/or	investigation, in my	opinion, death occ		date and place, and du	e to the cause(s)
To the	To the complet	×	29b. Signature and title of certifier	2 1 200	a I w	29c. Licen D522	se number		29d. Date signed (Mon February 7,	
. /			30. Name and address of person who Alan R. Segal, M.	D 1571 H	lugo Circ	e. Print)	r Spring	•		
	Sta Registr		31. Date filed (Month, Day, Year)	2 5 20 Registrar	s Sonature	H. Spen	k)			

crn		For State Unpond I to 1/22 a 22	State of Maryland / Dep	artment of Health and	Mental Hygien	000
			7,28a-f,Per ME, G828	Hiffeate of Death	Reg. No	. 2004 05919
P	hysicia	Decedent's Name (First, Middle, Last)	1.1.1: - 10	•	Date of Death Month Da	3. Time of Death
Right.	/Medica		Wolinsk	4b. City, Town, or Location of Dea	21	6. 2004 9:20 P
	.xamme	Johns Hopkins Hosp		Baltimore		N/A
Fu	neral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)			9. Birthplace (State or Foreign
Dir	ector	917-87-212	M 2□F 42 Yrs.	Months Days Hours Mil	11-15-6	Country) Ma
and	* =	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
Maryl	led a	i ma	Balt			1 2 Tes 2 □ No
the	r 288	10e. Street and Number	70 47 7 .	10f. Zip Code	10g. C	itizen of What Country?
h with	230 0	10e. Street and Number 22 River Vi 11. Marital Status 1 Never Married 22 Married	ew Ave	21225		115A
r dea	SE SE SE SE SE SE SE SE SE SE SE SE SE S	11. Marital Status		Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		14. Race - American Indian, Black, White, etc.
36 s afte	10,0		1 ☐ Yes 2 ② No	1 Yes 2 PNo Specify:	10017, 510.7	Specify: / / / /
1215-0036 within 72 hours atter death with the Maryland	E E	3 Widowed 4 Divorced 15. Decedent's Educe	Year or Dates:	dent's Usual Occupation	105 6	White
215 In 72	Medic	(Specify only highest grade	completed) (Give	kind of work done during most of we DO NOT use retired)	orking 160. F	Kind of Business/Industry
212 d with giene	2	Elementary/Secondary (0-12)	College (1-4or 5+)	ENgineer	SI	ITVEYING
be filed tal Hygi	vent	17. Father's Name (First, Middle, Last)			me (First, Middle, Maider	Sumame)
aryla should t	atic	o Milton Walin	USKIST.	ng Address (Street and Number or F	MABO	rwy
Maryland 21215-0036 Id 2 should be filed within 72 hours aff tith and Menial Hygiene.	in iden 27 is marked other than 'nature', or items 23e or 28s-r anow or other traumetic event, the Medical Example for that be invitible at	19a. Informant's Name/Relationship (Type				
e, P	thert	Kimberty Wolin	56: Wife 221	Rivery Ew		to Md-21222
Baltimore, permit. Pages 1 at Department of Hea	Important: If item any injury or other once.	1 2 Burial 2 □ Cremation 3 □ Re	moval from State cemetery, crer	matory or other place)		ocation - City or Town, State
Itin	injury	 4 □ Donation 5 □ Other (Specify) 21. Signature of Furieral Service Licenses 	A 1 HO LY	ROSGN 2	21-04 100	indalk md
Balt permit. Departr	any in	11/00/0x/0x/0	what I	2. Name and Address of Facility NESTEY Chavis 2007 Eastern	Jr. F.H.	1 212 21
		23a. Part I. Enter the disease or complice shock, or heart failure List only one	ations that caused the death. Do not ent	ter the mode of dying, such as cardia	c or respiratory arrest,	Approximate
Phys	ician	Immediate Cause (Final disease or condition	Narcotic Intoxication			Interval Between Onset and Death
/Me	dical	resulting in death)	Due to (or as a consequence of):			
Exan	niner	. Sequentially list conditions b.				
P	Sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of):			
xecute	I-tran	that initiated events resulting in death) Last	Due to (or as a consequence of):			
8760, sate be executed	the burial-transit	d.	sas to (or as a solitoqualities of).			
687	s the	d.				
Box 6	for use as	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of pregnancy			23d. Date of delivery
. 0	ad for	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of death 5☐	Ectopic pregnancy Other (specify)		Month Day Year
P in the	stached	9 Unknown	9□ Unknown			
>	9 9	Part II. Other significant conditions control	ibuting to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco i	use contribute to the cause of death?
Orc requi	should				1 ☐ Yes 2	□ No 3 □ Probably 4 □ Unknown
e taw	page 2 si				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	rector, pag				performed? 1 Yes 2 □ No	death? 1
Division of Vital Records, for Attending Physician: The law requires I after death Attenthe continues has been closed.	rector,	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	04	ath (Check only one)	
P P		1E1163 50140	I Inpatient 2 EH/Outpatien	4 Nursing	lome 5 Residence 28d. Describe how injur	
nding H.	e funer	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury foutherth, Day Year) 2/16/04 28b. Time of fourtedury 8:50	28c. Injury at Work? pM 1 ☐ Yes 2 ₺ No	unknown	y 33331103
DIVISIC II or Attence after death	by the	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 ACould not be determined	28e. Place of Injury - At home, farm, stre	-	28f Location (Street an	d Number or Rural Route Number,
ital of a straight of a straig	filled in	3	found in residence		1803 Fleet S	treet,Baltimore,MD 21222
DIVISION Of VITA Hospital or Attending Physician: 24 hours after death Funded Director After this partition	6	2 Medical Examine	rian: To the best of my knowledge, death r: On the basis of examination and/or inv	occurred at the time, date and place	a, and due to the cause(s)	and manner as stated.
To the h within 2	completely	29b. Signature and title of certifier	and manner stated.	,		
N N N	W.	250. Signature and three of certifier	6.	29c. License number O.C.M.E.	_	te signed (Month, Day, Year)
1	10	30 Name and address of annually	plated cause of dark the		rebi	mary 17, 2004
,	B	30. Name and address of person who com Theodore King M.I		111 Penn Street,	Baltimore, N	Maryland 21201
(A) +	State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1	· .	
R	egistra	0 - 0000	Same soon for the	onks/		

			For State Registrer AMEND #19a F		d / Depa	artment of H	lealth and	Mental Hyg	iene eg. No. 2004	05920	
)	Physicia /Medic Examin	an al er	Linda Lee Auka 4a. Facility Name (If not institution, give s Clinton Rehab C	rd street and number) enter		Clinto		h	ry 9,2004 4c. County of Deat Prince G	eorge	
	Funeral Director		5. Social Security Number 217-60-7716 Usual Residence of Decedent	7. Age (In yrs. Ia	nst birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year) 9. Bird 4 , 1952 Ma	nplace (State or Foreign untry) ryland	
	the Maryland 28e-f show	Director	10a. State 10b. County Maryland Charl 10e. Street and Number		Town or Lo	an Head		1	0g. Citizen of What Co	10d. Inside City Limits 1 XYes 2 No untry?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel, or items 23a or 28e-f show any injury or other treumatic svent, the Medical Examinar must be notified at mone.		by Funeral Di	1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give	206 Was Decedent of H If Yes, specify Cub	dispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black			
Baltimore, Maryland 21215-0036	within 72 hours iene. than "neturel" its Medical Exi	Completed b	3 Widowed 4 X Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2	Year or Dates: cation e completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire Shier	pation during most of wo d)	rking	16b. Kind of Business	Industry	
ryland 2	should be filed ind Mental Hyg is marked other umatic svent,	To Be C	17. Father's Name (First, Middle, Last) Edward Tyle 19a. Informant's Name/Relationship (Ty	TOP Print) SISTER	Nettie		Maiden Surname) Mack r, City or Town, State, 2	Zip Code)			
nore, Ma	Pages 1 and 2 s nent of Health ar ent: if Item 27 is ury or other treu		Patricia D. Jo 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F		MAryland 20c. Location - City or Indian H	Town, State					
Baltin	permit. Page Department Importent: It any Injury o		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or compt shock, or heart failure. List only of			ratory or other plants of the command of the command and Address of the command and the comman		al Home,			
	Physician /Medical Examiner		23a. Part1. Enter/the disease, or compile shock, or heart fallure. List only of Immediate Cause (Final disease or condition resulting in death)	est,	Interval Between Onset and Death						
68760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary Artery Disease Due to (or as a consequence of): Cardiac Arrhythmia Due to (or as a consequence of): End Stage Renal Disease							
P.O. Box 6	w requires that the death certificat, been signed by the attending phy should be detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3[□Ectopic pregnanc □ Other (specify) _	y		23d. Date of delivery Month Day Year		
	The law requires that the site has been signed by the bage 2 should be detache		Part II. Other significant conditions co	ntributing to death but not resu Mellitus	ulting in the u	inderlying cause gr	ven in Part I.		bacco use contribute to	the cause of death?	
I Reco	The larate has	Completed	Hyperten	sion				perfor	autopsy prior to completion of cause of death?		
Division of Vital Records,	Attending Physicien: Thir death. ector: After this certificate by the funeral director, pag	ation; To Be	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 Inspection 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. Inju	her: 4 Tursing	y at 28d. Describe how injury occurred k?			
Divis	To the Hospitel or Attending Phye within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	il Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	v) 	th occurred at the t	ime, date and plac	City or Tow	ause(s) and manner as	stated.	
•	To the Hos within 24 ho To the Fun completely	Medicai	(Check only 2 Medical Examione) 29b. Signature and title of certifier	iner: On the basis of examinal and manner stated.	tion and/or in	29c. Licen	opinion, death occ se number 5 (520	urred at the time, o	29d. Date signed (Month, Day, Year)		
1	B2 Sta Regist	ate	30. Name and address of person who control Pishdad, M.D. 31. Date filed (Month, Day, Year) FEB 13	1328 Soutl	nern	Ave., S	outh Ea	st, Was	hington,	D.C.10	

State of Maryland / Department of Health and Mental Hygiene 2004 05921 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:45 February 1, 2004 D. Anderson Louise /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Potomac Manor Care If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 4, 1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F Virginia 579-48-4229 89 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State items 23a or 28a-f show the Medical Examiner mant be notified at 1 Yes 2 □ No Director D.C. Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20007 4000 Tunlaw Rd., NW #503 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ent: If item 27 is marked other than "natural", or items 23 ury or other traumatic event, it a Midical Examinal mans. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Year or Dates: 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary Medical 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Stella Price Leach Vaughan Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5116 Briar Tree Dr., Dallas, TX 75248 Ann D. Coughlin / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Comfort Crematory Feb.9,2004 permit. Page Department of Importent: If any injury or once. Alexandria, Virginia 21. Signature of Fune of Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc. M00843 5130 Wisconsin Ave., NW, Washingon, Dc 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, durhear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease years /Medical Due to (or as a consequence of): **Examiner** vears Emphysema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Peripheral Vascular Disease **Vears** Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4XXVnknown 1 ∏ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2000 page 2 1 ☐ Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🗀 Inpatient Other: 4K Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ٤ 1 ☐ Yes ZXNo this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification; 5 Pending investigation 1XXNatural М 1 TYes 2 TNo death. 2 Accident Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 [Homicide 24 hours a 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35792 February 2, 2004 3 30. Name and address of person who com leted cause of death (Item 23a) (Type, Print) 50 W. Edmonston Rd., #504 Rockville, MD Swaroop G. Rao, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) souls FEB 1 0 2004 Registrar

			1 - For State Registrar	State o	f Marylan	d / Depa	artmen rtificat	t of H e of L	ealth a	and M		leg. No.	2004	
	Dhusisi		1. Decedent's Name (First, Middle	, Last)							2. Date of Dea Month Februa		Year	3. Time of Death
J	Physici /Medio			Delany		11ey					Februa			11:11A M
1	Examin	er	4e. Facility Name (If not institution		nber)				Location of				unty of Death	
			1001 La Grande 5. Social Security Number	Road 6. Sex	7. Age (In yrs.	last hirthday)		Lver	Spri		8. Date of Birt	h	ntgome 9. Birth	TY plece (State or Foreign
	Funeral Director		218-56-4792	1 ☐ M 2 🔼 F	77	Yrs.	Months		Hours	Min.	(Month, Da) May 20,	1926	Cou	Jersey
			Usual Residence of Decedent				1							
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2 No
	a-f.	ct :	Maryland Mont	gomery	Sil	Lver Sp								
	ih th or 24	Dire	10e. Street and Number 1001 La Grande	Pond			10f. Zip	0903				-	of What Cor ed Sta	
	ath w	Funeral Directo			edent Ever in U	C 12			isoanic Ori	inin2 (Sne	oify Vas or No		Race - Amer	
	ltem Item	in in	11. Marital Status 1 ☐ Never Married 2 ☑ Marri	Armed Fo	rces?	.3.	Il Yes, spe	cify Cuba	n, Mexican	n, Puerto	ecify Yes or No- Rican, etc.)		Black, White	e, etc.
336	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	/8		1 🗌 Yes	2 No	Specify:			Sp	ecity:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ta Mudical Examine maki be mailified at	Completed by	15. Deceden	t's Education st grade completed)		16a. Dece	dent's Usua kind of wo	al Occupa	ation	t of worki	na	16b. Kind	of Business/l	ndustry
218	thin 7	nple	Elementary/Secondary (0-12)	College (1		life.	DO NOT u	se retired	0			0 - 1	1 - 6	A 1. 4 to to
21	ygien ygien ygien yer th	S		(4	Į E	archi	tecti			(First, Middle,			Architecture
pu	be fill htal H d off	Be	17. Father's Name (First, Middle,					1	TO. MOUTE				mame)	
3	ould J Mer narke	P	Stephen K. Dela			19h Maili	na Address	(Street	and Numbe		len G	oldey	own State 7	in Code)
Maryland	d 2 st th and 7 ls r traur		Dr. Carroll O. A		band)	1001	La G	rande	e Roa	d Si	lver Sp	ring,	MD 20	903
ē,	Heal Heal tem 2		20a. Method of Disposition		20b. F	Place of Dispo cemetery, cre	osition (Na	me of	- 1		Date	20c. Locat	ion - City or	Town, State
ΘĽ	ages and of		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (5							Feb.	11,2004	eltsv	ille,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show among your or other traumatic event, this Madical Examples mark be notified at once.		21. Signature of Funeral Service			2	2. Name a	ad Addres	ss of Facilit	₩d C	rematio	n Serv	rices	
Ä	Ded die		trencen	e Foryan	+	ġ	33°G	ist A	Avenu	e Si	rematio lver Sp	ring,	мD 20	910
	B 4		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that of	caused the deat	th. Do not en	ter the mod	de of dyin	g, such as	cardiac o	or respiratory a	rest,		Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition		tastati	ic Ader	nocar	cinor	ma of	bla.	dder			Onset and Death 9months
	/Medical Examiner		resulting in death)		(or as a consec		10002							,
н	Examiner	_	Sequentially list conditions, if any, leading to immediate	b	(or as a consec									
	ed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ Due to	(or as a consec	querice oi).								
	be executed icien and burial-transit	xan	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):								
760,	be e sicien buris	calE												
687	eath certificate be executed attending physicien and for use as the burial-transit			0.										
Box	certifica anding ph use as th	N/	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnation		⊒Ectopic p	reanancy	,			23d	I. Date of deli	
	death e atten	icia	in the past 12 months? 1 \(\sum \) Yes 2 \(\sum \) No		nant at time of o		Other (s						Month	Day Year
P.0	at the by th	Physician/Med	9 Unknown											
	n requires that the death been signed by the atte should be detached for	by	Part II. Other significant condition Chronic Lymph:			sulting in the t	underlying	cause giv	en in Part i	I.				the cause of death?
ord	s uee pinot	ted	- United Eympin	1010							-			
Records,	S C	Completed									24a. Was	an 2 sy rmed?	24b. Were au prior to d death?	topsy findings available completion of cause of
E H	Th ate pag	S									1 Yes		1 🗆 Yes	2 🔀 No
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:		7====		O.A. Oth	0.0		(Check only o		201 (5	
of	\$ S	. To	1 Yes 2 No 27. Manner of Death	1 1 1 1	<u> </u>	ER/Outpatie		UA .	4 141		me 5 K Resident			city)
on	ding Ph h. After th funeral	tou	1 Natural 5 ☐ Pendi	ng (Mon	of Injury oth, Day Year)	Injury	м	28c, Injur Wor 1 🔲	k? Yes 2□]No				
Division	Attending r death.	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	e of Injury - At h	nome, larm, st	reet, factor	y, office			281. Location (. City or To		lumber or Ru	ural Route Number,
Ö	afte safte	ert	4 Homicide	build	ling, etc. (Speci	ny)					City or Tol	vii, Siale)		
	ospit hours uners ly fille	cai (29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the	e best of my kn	owledge, dea	th occurred	at the tir	ne, date ar	nd place, ath occur	and due to the	cause(s) an	d manner as	stated. to the cause(s)
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	one)	and man	ner stated.									
	To To COT	2	29b. Signature and title of certific	n A	nn			D359	e number				igned <i>(Montl</i> 9, 20	
	70		fund.	111 Jun	ullm	0							-, 20	
			30. Name and address of person					121	a #/.	00 17	heaton,	MD	20902	
		ata	Linda M. Bur 31. Date filed (Month, Day, Year) 32. F	Registrar's Sign		LOILY	1		W UU	iicatuli,	. עונו	20702	
	St Regist	ate . trar	FEB 1	0 2004	Geneva	19	de	oach	2					

				For State Ragistrar	State of Mai	ryland / Dep	artment o	f Health and M	Mental Hygiei		05923
				Hagistrar Decedent's Name (First, Middle, La.	st)				2. Oate of Death	Day Year	3. Time of Death
4		Physici /Medio		Charis Faith As			4b City Tow	n, or Location of Death	Feb. 4	2004 4c. County of Death	9:55 A M
		Examin	er	Southern Maryland		Center	Clint			Prince Ge	orges
		Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday		ear If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		place (State or Foreign ntry)
		Director		none	I□M 2¾0F	Yrs.	INOTALIS BE	50		004 Mary	
		and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	_ocation		<u> </u>		10d. Inside City Limits
		death with the Maryland rms 23a or 28a-f show r.p.ust be notified at	Į	MD Prince (Georges	Fort Was	hington				1 Tyes 2 No
		or 28a	Irec	10e. Street and Number			10f. Zip Coo	de	10g.	Citizen of What Cou	ntry?
		23a c	raiD	8384 Indian Head I			207			S. A.	I-di
~		er de di	Funeral Director	11. Marital Status XXNever Married 2 Married	12. Was Decedent En Armed Forces?	ver in U.S. 13	. Was Decedent If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puert	pecity Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
F	36	urs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀	No Specify:		Specify: Bla	ck
5. A.M	2-0	within 72 hours after ene. then "natural", or ite he Wedical Exprire	ted	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Giv	edent's Usual Or	one during most of wor	king 16b	. Kind of Business/Ir	dustry
55	21	ithin 16.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use re	stired)			
7:7	2	Hygier Hygier Thar ti	CO	0 17. Father's Name (First, Middle, Last	·)			18. Mother's Nan	ne (First, Middle, Maio	den Sumame)	
9	au	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriment must be multihed at once.	To Be	Michael Ashford				Jacquel	ine Higgin	S	
T	Maryland 21215-0036		-	19a. Informant's Name/Relationship (reet and Number or Ru			
Ö	, _			Michael Ashford -	- father			Head High			
+	Baltimore,	Tof Hor Miter		20a. Method of Disposition 1 ☐ Burial 2 \(\overline{Q}\) Cremation 3 \(\overline{Q}\)	Removal from State	20b. Place of Disp cemetery, cr				. Location - City or T	
71	ţi,	t. Pag rtant: rjury		* 4 □Donation 5 □ Other (Special Service Lice)	(y)	1		Home Feb.	7, 2004	Arlington	, VA
4	Bal	Depa impo any i		21. Signature of Fullerial Service Cite	Johnson				ell Funera	1 Home, P	. A.
•		Medical Examiner	Examiner	23a. Part1. Enter the disease, or son snock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c.	consequence of):	inter the mode of	tying, such as cardiac	s or respiratory arrest, Syndri	Tons)	D 20748 Approximate Interval Between Onset and Death
	760,	te be e ysician ne buria	cal	•	d						
	O. Box 68	Attanding Physician: The law requires that the death certificate be executed reath. sctor: After this certificate has been signed by the attending physician and better this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 10 □ Unknown	Fetal death 3	3 □Ectopic pregn 5 □ Other (specif		23d. Date of delivery Month Day Year		
	s, P.	res that tigned by		Part II. Other significent conditions	contributing to death bu	t not resulting in the	underlying caus	e given in Part I.		co use contribute to	the cause of death?
\sum	ord	requi	Completed						24a. Was an		
Y	3ec	2 8 2	d m						autopsy performed	l? death?	opsy findings available ompletion of cause of
9	la	ician: The lav certificate has rector, page 2	S	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes 2)☐ ath (Check only one)	(No 1 ☐ Yes	2 No
7	ž	/sicia s cert directo	o Be	examiner?	Hospital:	nt 2 ER/Outpati	ient 3□ DOA	Other	lome 5 ☐ Residence	e 6 □Other (Speci	fy)
7	٥٥	ding Phys h. After this funeral di	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time	of 28c.	Injury at Work?	28d. Describe how i	njury occurred	
*	Division of Vital Records, P.O.	i gift e	Certification; To	2 Accident investigatic 3 Suicide 6 Could not l 4 Homicide determined	on Diagon of Injur	ry - At home, farm,	М	1 ☐ Yes 2 ☐ No	28f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
		To the Hospital within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier Cartifying P	hysician: To the best of miner: On the basis of and manner sta	examination and/or	ath occurred at the investigation, in	ne time, date and place my opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	_	To the within 2 To the comple	Mec	29b. Signature and title of certifier				cense number		Date signed (Month	
		C>F0		> HAMA	ara 8	$n-\delta$.	D	-0034	302	2-4-	54
				30. Name and address of person who	completed cause of de	eath (Item 23a) (Typ	Se, Print)	-0034 suthenn	maryli	no the	spital
		St	ate	31. Date filed (Month, Day, Year)	3 Registra	r's Signature			,		

DHMH 17 Rev 1/2001

AS # FORD

State of Maryland / Department of Health and Mental Hygiene 2004 05924 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Bradberry ΑM Gloria Feb. 2004 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u>Southern Maryland Hospital Center</u> Prince George's Clinton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 25, 1 9. Birthplece (State or Foreign Country) 1924 Hagerstown, MD **Funeral** 1 □ M 2 🙀 F Months Days Hours 80 Director 217-12-2938 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at Charles 1 ☐ Yes 2X No Directo Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6203 Panther Court 20603 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ŏ f Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any injury or other traumatic event, the Ma Once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Health Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be Leroy Nichols Bessie Mae Baker 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Joy Hansen - Step-Daughter 7480 Marshall Corner Rd., Pomfret, MD 20675 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Gardens 2-16-2004 Waldorf, MD 22. Name and Address of Facility
Huntt Funeral Home
P.O. Box 156, Waldorf, MD 21. Signature of Funeral Service License M00053 MICC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) 100 **Examiner** Sequer stally list sundations, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine transit burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part If other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been signated to page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed Meumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Empatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide ö 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) Harpe and address of person who completed cause of death (Item 23a) (Type, Print) #2014 Clinton >4matts State Registrar

CY

BRAD BERRY

Damon Bowie 04-00976 cm

Amend Item 1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 200

State Amend Item#1, Per ME, 0829, 3/12/04eg Certificate of Death 1. Decedent's Name (First, Middle, Last) Damon Alejandro Christopher Bowie 2. Date of Death Month **Physician Bowie** February 03, Demon Alejandro C. Bowie 2004 10:42 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth
June 14, 1970

8. Birthplace (State or Foreign Washington, DC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1**∑** M 2□ F Hours 578-94-7966 33 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show r than "natural", or Itams 23a or 28a-f sho tre Medical Exercises must be redified at X□Yes 2 □ No Maryland Anne Arundel Severn Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8341 Flintlock Court 21144 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chesapeake Bay marked other than Seafood House Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager 12 th and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be \mathbf{L} A Bowie Josephine Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 Is
any injury or other train 8341 Flintlock Ct. Severn, Maryland 21144 LA Bowie/Father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Resurrection Cemetery 2/11/04 Burial 2 Cremation 3 Removal from State Clinton, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Codesoa MO1323 Adams Funeral Home P.A. Aquasco, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SHARP FORLE INOVALES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of) sician Box 68760. Physician/Medical the l phys as IF FEMALE esn. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by pe Completed 1 ☐ Yes 2 ☐ X\o 3 ☐ Probably 4 ☐ Unknown Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ ∀es 2 □ No 24a. Was an has autopsy performed? The page certificate 15 Yes 2 □ No Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 XYes 2 □ No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Attending After 5 Pending 1 Natural SUBTECT WAS STABBED AND CUT death. 2/3/04 investigation 8:30 P 1 ☐ Yes 2 ☑ No 2 Accident within 24 hours after death To the Funeral Director: the 1 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) IASCULAND NOVEE OF CORRECTION filled in by 4 R Homicide ŏ CORRECTIONS JAIL Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 04, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO ANA Mp 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 13 Registrar 2004

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 5:00AMFrances Naomi Elburn Boulter February 4, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Chestertown Nursing & Rehab. Ctr. Chestertown Kent 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1□M 2□F 216-10-2047 92 Director Apr. 14, 1911 Maryland Usuat Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or flems 23a or 28a-1 shov traumatic event, the Medical Extringst must be redified at 28a-f show 1☐¥es 2☐No Director Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural, or Items 23a or 2 any nighty or other fraumatic event, the Medical Extenti at mart be 1n once. 5795 Chesapeake Villa Road Apt. 111 21661 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Sewing/ Coltege (1-4or 5+) 8th 0 Seamstress Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carroll Newton Elburn Henrietta Elizabeth Joyner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Dowling P.O. Box 42, Rock Hall, Maryland 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Wesley Chapel Cemetery 2/8/2004 | Rock Hall, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home, P.A. Aul 130 Speer Road, Chestertown, Maryland 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Al Theimis **Physician** YV. /Medical Due to (or as a consequence of): **Examiner** Dehudation if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons a uence of): Examine The law requires that the death certificate be executed burial-transit COPD ex cum ato and Due to (or as a consequence of) physician P.O. Box 68760 Physician/Medical the the attending IF FEMALE: esn. 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy detached for in the past 12 months? Month Day 4☐Pregnant at time of death Year 5 Other (specify) 1 Yes 2 No þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 N6 Completed 1 Tyes 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 20 No certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one) examiner? Hospital: 1 ☐ Inpatient 1 Tes Other: Medical Certification: To 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; the f 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 9 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) MD 051733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Frederick Delboy, M.D. 6602 Church Hill Road, Chestertown, Maryland 21620 32. Registr s Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

FEB 0 6

State of Maryland / Department of Health and Mental Hygiene 05927 2006 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2004 **Physician** 6:55PM 10 WILLIAM F. BOUNDS /Medical 4c. County of Deeth Kent 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Chestertown Chestertown Nursing Rehab. Ctr. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year 03 06 1908 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1X M 2□F Hours 95 076-07-9384 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-1 ehow other traumatic event, the Medical Exametric must be motified at X Yes 2 No Chestertown Funeral Director MD Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 22526 Goose Hollow Drive USA death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Suffolk Constr. Co. Manager 12th 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any jury or other traumatic event gines. 17. Father's Name (First, Middle, Last) Be Edna Stewart William F. Bounds, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD21620 22526 Goose Hollow Dr. Chestertown, Sue Bounds - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Dover, DE Capitol Crematory 2/11/04 * 4 □ Donation 5 □ Other (Specify) Service 821 W. St. Annapolis, MD 21401 21. Signature of Funeral Service Licensee 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Physician Law de /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been signated should be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s certificate 1 Yes 2 1No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2/11/04 D21313 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) flow Ane, Chesterlown, MO 21620 415 W 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,4$ 05928 Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 3:00 a M February 4, 2004 Kenneth Thomas Burns /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery 2712 Elnora Street 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Hours Months 1 XM 2 F 28, 1955 49 Washington, DC Jan. Director 220-58-8407 Usuat Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County rai', or items 23s or 28s-f show Exeminer must be notified at 1 ☐ Yes 2 ☑ No Silver Spring Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 20902 USA 2712 Elnora Street death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No "natural', or Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed or than "natur. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. House of permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce. 5+ Communications Specialist Representatives 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be <u>Helen Kastorf</u> 2 John Thomas Burns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2712 Elnora Street, Silver Spring, MD 20902 Edward R. Burns/ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 9 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Alexandria, Virginia ⁴ 4 □ Donation 5 □ Other (Specify) 2004 Metropolitan Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, AnneMeure MD20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** Diabetes Mellitus- Type I Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a panseouence of: Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. attending physicien by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav jo in the past 12 months? 5 Other (specify) ☐Yes 2☐No detached Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 反 No Coronary Artery Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Peripheral Neuropathy autopsy performed? 2 🗆 No 1 ☐ Yes 2 🔀 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 XYes 2 No 2 ER/Outpatient 3 DOA Certification: To 11/2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 | Homicide within 24 hours a To the Funerel I filled 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Dey, Year) 29b. Signature and time of certifier 29c. License number D36046 February 6, 2004 use of death (Item 23a) (Type, Print) ddress of person who completes 30. Name and 10215 Fernwood Road, #405, Bethesda, MD 20817 John J. Merendino M.D. 31. Date filed (Month, Day, Year) FEB 0 9 32. Registrar's Signature State 2004 Care goton Jacks Registrar

		í	For State Registrar		State o	f Marylar		artmen rtificat			and M	lental Hy	giene Reg. No.	2001	05	929	
	Dhuniai		1. Decedent's Name (First, Mic	ddle, Last)								2. Date of De Month	Day	Year	3. Time of	Death	
	Physicia /Medic		Minoo			n Brown		1				January			1300	M	
	Examin	er	4a. Facility Name (If not institute Suburban Hosp		treet and nu	mber)		Beth	esda				M	ounty of Death ontgome	ery		
	Funeral Director		5. Social Security Number 218-94-9642	6. Sex	M 2₫F	7. Age (In yrs. 40	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Jan I	1964	9. Birth	Birthplace (State or Foreign Country) an		
	and		Usual Residence of Decedent 10a. State 10b. Cour	nty		10c. Ci	ty, Town or Lo	cation							10d. Inside Ci	ty Limits	
	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. rmarked other then "natural", or Items 23a or 28a-f show marked other then "natural", or Items 25a or 28a-f show marke other the Modical Exacting Insel be notified at	Director	-	tgome	ry	F	Rockvil			-			10- 6:1:	1 ☐ Yes 2 No			
		ai Dire	10e. Street and Number 11801 Rockvil	le Pi	ke, #1	712			0852				Uni	ted St.	ates		
936	urs after dea	by Funerai	11. Marital Status 1 Never Married 2 N 3 Widowed 4 Divorce	larried	12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	V8	in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:							Black, White Black, White Specify: W	etc.		
215-0	ithin 72 hours ite. ite. "natural", ite. Medical Exe	Completed	15. Decec (Specify only hig Elementary/Secondary (0-12		cation completed) College (1-4or 5+)		dent's Usu kind of wo DO NOT u	rk done d se retired	ation during mos	t of work	ing		of Business/f	ndustry		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important; if Item 27 is marked other then "natureny injuryer other traumatic event, tra Madical ong injuryer	Be	17. Father's Name (First, Midd Mashalah	lle, Last) Barz			<u> </u>	LSabi	u	18. Mothe		e (First, Middle	Ĺ	umaṃe)			
Maryl	d 2 should the and Me (7 is mark traumatic	To	19a. Informant's Name/Relation Maryam Janga)	19b. Maili 1180	ng Address	(Street a	and Number	or Aur ke 352	#1712	er, City or	Town, State, Z	ïр Code)		
Baltimore, N	ages 1 and int of Health it; if Item 27		20a. Method of Disposition 1⊠ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	on 3 □R		20h	Place of Dispo cemetery, cre arklawn	sition (Na.	ne of	1		Date	20c. Loca	ation - City or `ville,	Fown, State		
Baltir	permit. P Departme Importan eny injur		21. Signature of Funeral Serv		e de	/	R 9	2. Name a app F 33 Gi	d Addres	ss of Facilit al An venue	d Cr	emation Lver Spr	n Serv	rices MD 209	10		
	Physician		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a.										Approximat Interval Bet Onset and	ween			
	/Medical Examiner		resulting in death)		Due to	(or is a conse	quence of):								day	5	
1/04	cuted nd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events	1	Due to	(or as a conse	quence of):										
1/3	ite be executed hysician and he burial-transit	ical Ex	resulting in death) Last		Due to	(or as a conse	quence of):										
ο <i>β</i> . 0. Box 68	attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	2	1 Live	itcome of pregr birth 2 Fet nant at time of nown	al death 3	□Ectopic p □ Other (s		,			23	d. Date of deli Month	,	Year	
Mivido	requires that the desert signed by the a	by	Part II. Other significant con-	ditions cor	ntributing to	death but not re	sulting in the t	underlying	cause giv	en in Part I			robacco us	e contribute to	the cause of cobably 4 🔲		
_ e	The law requirate has been spage 2 should	Completed										24a. Was auto perfo 1 🗆 Yes	psy prmed?	prior to death?	topsy findings completion of c	available ause of	
3 E	ysician: Th is certificate director, pag	Be	25. Was case referred to med examiner?	-	An amitada				0#		e of Dea	th (Check only	one)				
3,70	Physic this seal di	on: To	1 ☐ Yes 2 🕱 No 27. Manner of Death 1 💆 Natural 5 ☐ Per	nding	28a. Date		28b. Time of Injury	_	28c. Injur Wor	4 140		ome 5 Resi			pify)	-	
razin E	teat tor:	Certification:	3 ☐ Suicide 6 ☐ Co	estigation uld not be ermined	28e. Plac	e of Injury · At I ding, etc. <i>(Spec</i>	home, farm, si			Tes Z	140	28f. Location (City or To	Street and wn, State)	Number or Ru	ral Route Nun	iber,	
3ril	spita hours ineral y filled	ledical Ce			ner: On the							, and due to the rred at the time,				;)	
7	To the Ho within 24 To the Fu	Me	29b. Signature and title of cer	tifier			0			e number	93	8	29d. Date	signed (Month	Day, Year)		
	(30. Name and address of per Kian Kavian	son who co	D.; 86	use of death (Ite	om 23a) (Type George	Print)					-/-				
	Sta Regist	ate rar	31. Date filed (Month, Day, Y	ear) 201		Registrar's Sign	nature 4	de	ak.	2				<u>-</u>			

		1 - For State of Maryland	/ Depa	artment of H tificate of L	ealth a Death	nd Mental	Hygien		05	930
Di i .		Decedent's Name (First, Middle, Last)				2. Date Mont		ay Year	3. Time of	
Physic /Medi		John Brenner					uary (6, 2004	5:30	a M
Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	f Death		. County of Deal		
		Randolph Hills Nursing Home		Wheato		Mus Is =		Montgome		-
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Mont	h, Day, Year) Co	hplace (State of ountry)	ir For e ign
Director		578-26-1907 142 M 2 87	113.			Jan.	25, 1	91/ Oh:	10	
and and		10a. State 10b. County 10c. City, T	own or Lo	cation					10d. Inside Ci	ty Limits
Many 1 sho	ō	Maryland Montgomery Who	eaton						1 🗌 Yes	2 ⊠ No
the 128a	rec	10e. Street and Number		10f. Zip Code			10g. C	itizen of What Co	ountry?	
3a or	Funeral Director	12412 Connecticut Avenue		20906				USA		
death ms 2	Jera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig	in? (Specify Yes	or No-	14. Race - Ame Black, Whit		
or its		1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married	ł		Specify:	, r dono rnoun, oc	.,	Specify: Whi		
1215-0036 within 72 hours after death with the Maryland ene. than "natural; or itams 23e or 28e-1 show the Mical Exercites Court to motified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1944—	46							
21215-0036 ad within 72 hours aff gigiene. ar than "natural", or the Mulic Exerci	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Deced	dent's Usual Occupa kind of work done o DO NOT use retired,	ation <i>Juring</i> most	of working	16b. I	Kind of Business	Industry	
12 light 12	E E	Elementary/Secondary (0-12) College (1-4or 5+)		ıster	,		Т.	nsurance	.	
d 2 filed v Hygie other t		17. Father's Name (First, Middle, Last)	Auju	Stel	18. Mothe	r's Name (First, M				
d be f	Be	Andrew Brenner				Sara Rei	nert			
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural, or items 23e or 28e-f show other traumatic svent, the Marical Exemples court of the notified at	2		19b. Mailir	ng Address (Street a				or Town, State,	Zip Code)	
Ma d 2 s th an th an trau			12412	Connect	feut /	Avenue 1	Wheato	n MD 20	1906	
Heal Heal		20h Plac	e of Dispo	sition (Name of natory or other place	1	bruary 1	20c I	ocation - City or		
noi ages ont of tt: if if		1 MBurial 2 □ Cremation 3 □ Hemoval from State		in's Cemet		2004		eltenham	. Marvl	and
Baltimore, Ma permit. Pages 1 and 2 Department of Health a important: If Itsm 27 is any injury or other tra once.		21. Signature of Euneral Service Licensee	-	Name and Addres					, mary	and
Bal Permi Depa Impo Impo		Richard & Halyo		O Univers					. MD 20	901
		23a Part 1 Enter the disease, or complications that caused the death.							Approximat Interval Bet	e
Chichology		shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia Pneumonia		Onset and I	Death					
Pnysician /Medical		disease or condition resulting in death) PREUMOTIA Due to (or as a consequent	nce of):							
Examiner		Sequentially list conditions b.								
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ice of):							
cuted	Examiner	that initiated events c.								
760, te be executed ysician and te burial-transit	Ä	resulting in death) Last Due to (or as a consequen	ice or):							
~ ~ ~	dicai	d			-					
ம் 🖺 நால்	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	.,					22d Date of do	linear	
Box eath cert attendin for use	ian	23b. Was decedent pregnant 1 Live birth 2 Fetal de	eath 3	Ectopic pregnancy Other (specify)			1	23d. Date of de Month	-	Year
o.O. It the de by the a tached f	sic	1 Yes 2 No 9 Unknown 4 Pregnant at time of deat	n 3⊑	Other (specify)		-				
P.O.		Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying cause give	en in Part I.	23e.	Did tobacco	use contribute to	the cause of c	death?
0 8 5 8	by	Congestive Heart Failure					1 ☐ Yes 2	2 No 3 P	robably 4 🔯	Jnknown
cords, wrequires been sign should be	etec	Congestive meate raging				242	Wasan	24h Were au	topsy findings	available
N 8 8 0	Completed						autopsy performed?	prior to death?	completion of c	ause of
al Re					00.00		Yes 2⊠N	o 1 ☐ Yes	2 □ No	
of Vital Physician: This certificateral director, p	Be	25. Was case referred to medical examiner? Hospital:	1/Outantine	nt 3□ DOA Othe	000	of Death Check	-	6 Other (See	noifu)	
on of Vital ding Physician: 1 h. After this certificat funeral director, p.	1.0	1 ☐ Yes 2 ☑ No ☐ 1 ☐ Inpatient 2 ☐ ER 27. Manner of Death 28a. Date of Injury 28	Bb. Time of	IL 3LI DOA	4 (2) NU		ribe how inju		City)	
fing Afte	盲	1 ⊠Natural 5 ☐ Pending (Month, Day Year)	Injury		k? Yes 2.⊟1	No				
Si tent	lica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home	e, farm, str	eet, factory, office		28f. Loca	tion (Street a	and Number or Ri	ural Route Num	ber,
in Little	Certification:	4 Homicide building, etc. (Specify)				City	or Town, Sta	re)		
Divi To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1⊠ Certifying Physician: To the best of my knowle	odge, deatl	h occurred at the tim	ne, date an	d place, and due t	o the cause(s) and manner as	s stated.	
ns Ho ns Fu Netely	ledical	(Check only one) 2 Medical Exeminer: On the basis of examination and manner stated.	and/or in	vestigation, in my or	pinion, deal	th occurred at the	time, date ar	nd place, and due	o to the cause(s)
To 11 withir To 13	×	29b. Signature and title of certifier	//	29c. License	e number		29d. D	ate signed (Mont	th, Day, Year)	
10		(long & Coac	V.	W D52	261		Fe	bruary	7, 2004	
46		30. Name and address of person who completed cause of death (item 2:	3a) (Type,	-						
		Alan R. Segal M.D.	15	17 Hugo C	ircle	, Silver	Sprin	g, MD 20	0906	
_	ate	31. Date filed (Month, Day, Year) SER 1 0 2004 32. Registrar's Signatur	0 4	Sporks	/					
Regist	rar	FEB 1 0 2004	/-	La Comp						

		1 = For State Registrar	State of Mar	yland / D	epartment of F Certificate of	lealth ai <i>Death</i>	nd Mental Hy	giene Rog. No.	2001			
Physici /Medi		1. Decedent's Name (First, Middle, La Eleanor		Brady			2. Date of De Month Februa	Day	Year 0, 2004	3. Time of Death 8:05 PM		
Examir Funeral Director			s- Bethesda	In yrs. last birth	4b. City, Town, of Rocky anday) If Under 1 Year Months Days	ville		th	County of Death Ontgomer 9. Birth Cou			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydren. In the Maryland Important: If them 21's marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, the Madical Examinar must be notified at 2000.	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
	Funerai Dire	10e. Street and Number 3605 Dunlop St 11. Marital Status	reet 12. Was Decedent Even Armed Forces?		10f. Zip Code 208 13. Was Decedent of Fill Yes, specify Cub.		n? (Specify Yes or No Puerto Rican, etc.)		zen of What Cou USA 14. Race - Amer Black, White	ican Indian,		
72 hours afte	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E (Specify only highest g.	ducation	16a. [1 ☐ Yes 2 ☑ No Decedent's Usual Occup (Give kind of work done	Specify:		Specify: White 16b. Kind of Business/Industry				
al Hygiene. Jother than 'vent, the Mark	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Las	College (1-4or 5+)		iife. DO NOT use retire omemaker	18. Mother		Own Home				
nd 2 should that and Ment 27 is marked referenced to the should the should the should be should	Tof	William Buchro 19a. Informant's Name/Relationship Peter J. Brady/	(Type, Print)	and Number	Eveline Morral Route Numb Greenbelt,	er, City o	r Town, State, Zi	p Code)				
Pages 1 ar tment of Hea tant: if item		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	ebruary 19 2004	Cheltenham, Maryland								
permi Depar Impo		21. Signature of Funeral Service Lice The Land I 23a. Part 1. Enter the disease, or conshock, or heart lailure. List only	Tecles mplications that caused th	e death. Do no	500 Univer	sity B		lver	e Inc. Spring	Approximate Interval Between Onset and Death		
Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events a. Acute Cholecystitis Due to (or as a consequence of): b. Preusonia Due to (or as a consequence ol): c. Schizophrenia										
eath certificate be executed eath certificate be executed attending physician and for use as the burial-transit	edicai	that initiated events resulting in death) Last										
The law requires that the death certified has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	/as decedent pregnant the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Utakanan									
w requires that been signed should be del	by									o use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available		
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To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	he	/ear) 28b. Ti	ime of 28c. Injury Wo	4 LX Nurs		how injury	y occurred	,,		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the it	cai Certifi	4 ☐ Homicide determine 29a. Certifier 1 ☑ Certifying F	building, etc.	(Specify) my knowledge,	m, street, factory, office	me, date and	City or To	wn, State; cause(s)	and manner as	al Route Number,		
To the H within 24 To the Fi	Medicai	29b. Signature and till en ficertifier	and manner state		29c. Licens	se number	29d. Date signed (Month, Day, Year)			Day, Year)		
6+1		30. Name and iddress of person white M. Rit	o completed cause of dea		D301 Type, Print) 304 Physicia		ane, #221,		cuary 11			
St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 1 2 21	32. Begistrar		1 Sparks		0					

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician **FEBRUARY** BRADLEY 9 2:29 P M JEAN BARNSLEY 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery General Hospital 01ney Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | No v . 12 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**⊠**F Yrs. 1914 218 05 0093 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified al 1 ☐ Yes 2 No Md. Howard Woodbine Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15475 Old Frederick Road 21797 United States death t Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify þ 3 Widowed 4 ☐ Divorced "naturst" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry rmii. Pages 1 and 2 should be filed within spartment of Health and Mental Hygiene. prortant: if them 27 is marked other then "I yoliany goother traumatic event, the Mast pre." Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 4 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barnsley Catherine Cashell Alexander Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15435 Old Frederick Rd., Woodbine, Md. Donna Bradley Brown / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury of once. * 4 ☐ Donation 5 ☐ Other (Specify) Oak Grove Cemetery 2/13/04 Glenwood, Md. 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee murie 20882 Box 5038, Laytonsville, Md. P. O. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) disease erebrovascular 1WKEKS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consumence of or Attanding Physicien: The law requires that the death certificate be executed Due to (or as a consequence of). attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 28 No Month Day Year 4□Pregnant at time of death P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ EUMONIA 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No DIVERTICULIAS 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 🏂 No 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident after death the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifie and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 10, 2004 D23174 MAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2901 OLNEY, SANDY SPRING RD ; DINEY, MARYUND DENNIS M, HANNON MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 11 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:50 am February 6, 2004 Brabec Klara /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Potomac Manor Care- Potomac If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Oct. 4, 1904 Czech Republic 213-38-2764 99 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County *how ir then "natural", or Items 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 ☒ No Directo Maryland Montgomery Potomac 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 20854 USA Funeral 12000 Piney Meetinghouse Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Family Home None Housekeeper permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury. or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12000 Piney Meetinghouse Road, Potomac, MD 20854 Janet Edwards/ Personal Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition February 9 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 2004 Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 lho 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dementia resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Osteoporosis and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No director, page 2 certificate has 1 ☐ Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 3□ DOA မ 1 ☐ Yes 2 🔀 No 2 ER/Outpatient this the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: After t 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No М within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title # D35792 February 6, 2004 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 50 W. Edmonston Dr. #504, Rockville, MD 20852 Swaroop Rao M.D. 31. Date liled (Month, Day, Year) 32. Registrar's Signature State 09 FEB Registrar

		•	For State Registrar	State	of Maryla	nd / Depa <i>Cer</i>	artment of F tificate of	lealth and Death	F	eg. No.	04 05934
Ī	Physici /Medic		1. Decedent's Name (First, Midd Joseph	(e, Last)	W.		Bloch		2. Date of Dea Month Februar	y 1, 200	
	Examin	er	4a. Fecility Name (If not institution 10400 Rodney Rossial Security Number			s. last birthday)	4b. City, Town, or Silver If Under 1 Year			4c. County of	nery
å	Funeral Director		089-07-1173 Usual Residence of Decedent	1⊠M 2□F	92	Yrs.	Months Days	Hours Min	(Month, Day	3,1911 No	ew York, New York
	Maryland a-f ehow iffed at	tor	Maryland Monts	gomery	10c. (Silver	cation Spring				10d. Inside City Limits 1 ☐ Yes 2X No
	th with the 23a or 28	ai Dire	10e. Street and Number 10400 Rodney	Road			10f. Zip Code 2090			Og. Citizen of Wh United	States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if Item 27 is marked other than "naturel", or Items 23a or 28a-1 show any highly prother traumatic event, the Mudicel Eracinal cancer collect an once.	by Funeral Director	11. Marital Status 1 Never Married 2 A Mai 3 Widowed 4 Divorced	ried 1 XYes	2 □ NoWW	тт	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 21 No	dispanic Origin? (5 an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
Maryland 21215-0036	within 72 ho ene. than "natur he Medicel	Completed		nt's Education est grade completed College 4	d) (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo		16b. Kind of Busi Federal (ness/Industry Government
land 2	uld be filed Aental Hygi rked other itic event, ti	To Be Co	17. Father's Name (First, Middle Ike	Bloch				18. Mother's Na Mary	me (First, Middle,	Maiden Sumame) Paslir	
, Mary	and 2 shoresth and Amark mark trauma		19a. Informant's Name/Relation Gertrude Bloc		001	10400	Rodney	and Number or R Road Sil	ver Spri	ng, MD 2	20903
altimore,	Pages 1 tment of H tent: If Ite		20a. Method of Disposition 1 Burial 21 Cremation 4 Donation 5 Other (Specify)		Chesape	ake Cremat	ory Feb		20c. Location - Ci Beltsvil	le, MD
Ba	Depa impoa impoa any ir	1 18	21. Signature of Funeral-Service	ist Tan		93	3 Gist A	venue Si	remation lver Spr	ing, MD	20910 Approximate
3	Physician /Medical Examiner		23a. Part 1. Enter the disease of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a		inson's	Disease				Interval Between Onset and Death 10 Yrs
8760,	ficate be executed physician and is the burial-transit	dicai Examiner	Sequentially list conditions, 23, 13 and 15	C	o (or as a cons						
.O. Box 68	that the death certifica ed by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	outcome of preg birth 2 Fe gnant at time o	etal death 3	Ectopic pregnanc Other (specify)	y		23d. Date Month	
a	quires that n signed by uld be deta	by	Part II. Other significant condit	ions contributing to	death but not r	esulting in the u	nderlying cause gi	ven in Part I.			ute to the cause of death?
I Records,	The law requires that sate has been signed by page 2 should be deta	Completed								sy pri med? de	ere autopsy findings available or to completion of cause of ath? Yes 2 \(\) No
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3□ DOA Ot		nath <i>(Check only o</i>		(Specify)
ion of	After une	ation: T	E	28a. Dating (Mo	te of Injury onth, Day Year)		f 28c. Inju Wo	ry at		ow injury occurred	
Division	in Diriginal	Certification:	4 Homicide	mined 200. Fid	lding, etc. (Spe	ocify)	reet, factory, office		City or Tow	m, State)	or Rural Route Number,
	the Hospital hin 24 hours a the Funeral I upletely filled	edical	29a. Certifier 1 (Check only 2 Medical one)		the best of my keep to basis of exam anner stated.	ination and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occ	e, and due to the curred at the time, o	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
)	To the within comple	Σ	29b. Signature and title of centre	l Roses	efre.		D0983		1	Feb. 4,	(Month, Day, Year) 2004
	20+1		30. Name and address of person Barry Rosenbau	0700 7			Print) e Kensing	gton, MD	20895		
Ĭ	Sta Regist	ate rar	31. Date filed (Month, Day, Yea		Registrar's Sig		Span	h			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2.2.2

				For State of Maryland / Dep. State of Maryland / Dep. Ce	artment of H rtificate of L	Death	R	leg. No.	04	05935
_		Physicia		Decedent's Name (First, Middle, Last) Richard Alan Bird			2. Date of Dea Month Januar	Day	Year 04	3. Time of Death 1:20P M
		/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County o	f Death	
				Joseph Richey	Baltim					
		Funeral Director		5. Social Security Number 6. Sex 100 M 2 F 7. Age (In yrs. last birthday, 43 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct. 10	7. Year) 0,1960	9. Birthpla Count MiC	ace (Stete or Foreign n) higan
		show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L					10	d. Inside City Limits
		Ba-f s	cto	Virginia Fairfax Alexand			1.			
		sath with the Maryland s 23a or 28a-f show the partition at	ai Dire	10e. Street and Number 6315 Landess Street	10f. Zip Code 22312			USA	nat Count	ry !
E S	215-0036	after de or Item	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race Black Specify:	- America , White, e	etc.
3	5-0	72 hours natural', dical Ext	etec	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occup	ation during most of worki d)	ng	16b. Kind of Bus	siness/Ind	ustry
	2121	filed within Hygiene. other then " ent, the We	Completed	Elementary/Secondary (0-12) College (1-40r5+)	countant	a)		Accour	nting	1
3	land ;	be filed wil stal Hygien st othar th event, the	Be	17. Father's Name (First, Middle, Last) Alan R. Bird		18. Mother's Name)	
	3	should be and Mental is marked of sumatic even	²		ing Address /Street	and Number or Rura			State. Zio	Code)
7	Mary	D = 1 = 1			5 Landess			dria, Viro		
0	ore,	es 1 and 2 of Health of Hem 27 I if Item 27 I		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of matory or other place	ce)	ate	20c. Location - 0	City or Tov	wn, State
30	Baltimore,	permit. Pages 1 and Department of Healimportant: If Item 2 any injury or other once.		`4 □Donation 5 □Other (Specify) Metropo		atry 02/0 ss of Facility Old				
)	Ba	permit. Departr Imports any inj		A delosto 1	205 Belle	Haven R	d. Alex	andria,		
_	×	₹ ₹\$		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	iter the mode of dyin	ng, such as cardiac d	or respiratory are	rest,		Approximate Interval Between Onset and Death
0		Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	10077401.					yrs
decessed.	В	Examiner	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
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	ds, P.O.	uires that signed by	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	ven in Part I.			bute to the	e cause of death? ably 4 Unknown
3	Vital Records,	iiclan: The law requirr certificate has been si rector, page 2 should t	Completed				24a. Was a autop perfor 1 Yes	med2 de	/ere autoprior to coneath?	osy findings available apletion of cause of
3	ita		Be C	25. Was case referred to medical		26. Place of Death				
	of V	hysici his ce	To	examiner? 1 Yes 2 Two Hospital: 1 Inpatient 2 ER/Outpatie		4 Nursing Ho				ngt Hogice
5	ouc	Attending Physician: r death. ector: After this certifica by the funeral director, i	tlon:	27. Manner of Death 1 X Natural 5 Pending (Month, Day Year) 2 Accident investigation 2	Wor	ry at rk? Yes 2 □ No	28d. Describe h	ow injury occurre	ed	
MAR	Division	= 5 te €	edical Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, s			28f. Location (S City or Tow	Street and Numbern, State)	or Rural	Route Number,
() ()		To the Hospital within 24 hours a To the Funeral Completely filled	lical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.						
-	_	within 2 To the comple	Med	29b. Signature and title of certifier	29c. Licens	se number		29d. Date signed	(Morith, L	Day, Year)
		6		Yellin Grenan III Me	D33	40	4	01/30/	200	1-
					HARLES 5	T BALTIM	at N	10 ZIZI	2	
	(t)	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 9 2004 32. Registrar's Signature	Spark					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05936 Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** Irene BEER 2004 6:00 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery 10617 Ordway Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (St. Months | Days | Hours | Min. | Sept. 199, 1920 | Germany 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 TXF 83 020-32-5251 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland rtment of Health and Mental Hygiene.
 rtent: If item 27 is marked other than "naturel", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State rel', or items 23s or 28s-f show Examiner must be notified at 1 Yes 2 No Funeral Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 United States 10617 Ordway Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status □Yes 2 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Artist Art 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Golda Rifka Mislevitz Joel Reiner 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Ruth Beer Bletzinger, Daughter 213 Leighton Ave., Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 02/08/04 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 21. Signature of Funeral Service License 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home, Inc. 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stroke Month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by peq 1 Yes 2 No 3 Probably 4 Wunknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2X No 1 Yes 2 No I ☐ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) Hospital: 0 1 ☐ Yes 2 TNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Oescribe how injury occurred Certification: After Injury 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and Mile of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 56017 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore St. Baltimore, MODIDOI He Jamie W 31. Date filed (Month, Day, Year) FEB 1 0 32. Registrar's Signature State 2004 Registrar DHMH 17 Rev 1/2001

4	_	For 2/9/04 State Registration end 2527 28a - 1 Decedent's Name (First, Middle, Last)	vor ME HUCcr Ce	rtificate of Death	Reg. 2. Date of Death Month	No. 3. Time of Do
Physicia /Medic Examin	al -	Barbara Joan		n 4b. City, Town, or Location of Deat	January	28, 2004 2:45 p
LAGITHII		Washington Advent:	ist Hospital	Takoma Park		Montgomery
Funeral Director		5. Social Security Number 6. Sex			8. Date of Birth (Month, Day, Ye 1/12/194	9. Birthplace (Stete or F
2 (100		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City
ohov mg at	20	MD Prince (1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1 ⊠ Yes 2
notifi	rect	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
23e o	ai D	3902 37th Place		20722		U.S.A.
it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or itams 23e or 28a-f ehow or other traumatic event. The Mydical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Amarried 3 Widowed 4 Divorced	1 ☐ Yes 2 🕅 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
"neture	Completed by	15. Decedent's Edu (Specify only highest grade	completed) (Give	dent's Usual Occupation b kind of work done during most of wo DO NOT use retired)	rking 16b	. Kind of Business/Industry
r then	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	ndow Clerk		S. Postal Service
office office vent.	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Na	ne (First, Middle, Maid	den Sumame)
Menta arked	ToE	Edward Francis de	Bethizy	Ther	esa Eleano	or Russell
n and Mental Hygiene. Is marked other then "reumatic event, the Med		19a. Informant's Name/Relationship (Ty		ing Address (Street and Number or Ri		57741
Health		Jackie Lee Baughan 20a. Method of Disposition		37th Place, Bren		20722 Location - City or Town, State
Department of Health a Important: If item 27 is any injury or other tra		1 Burial 2 ☐ Cremation 3 ☐ R		osition (Name of imatory or other place) oln Cemetery 1/31		Frentwood, MD
oortant:		 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 		2. Name and Address of Facility	72004	renewood, rib
Impo any ic		Clared of to or	100	739 Baltimore Ave	., Hyattev	ille, ND 20781
ysician Medical kaminer	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events	Due to (or as a consequence of): Due to (or as a consequence of):	Minester Company	line?	Onset and De
ed by the attending physician and detached for use as the burial-transit	by Physician/Medical Exa	resulting in death) Last		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Ye
P 90		Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the cause of dea 2 ☑No 3 ☐ Probably 4 ☐Un
ate has been s page 2 should	Completed				24a. Was an autopsy performed	
- i	Be (25. Was case referred to medical examiner?			ath (Check only one)	
this aldi	5	1 Ø Yes 2⊠ N o	lospital: 1 Inpatient 2 ER/Outpatie		dome 5 Residence	e 6 Other (Specify)
r death. ector: After by the funer	Certification:	27. Manner of Death 1. Sivatural 5 ☐ Pending 2. Accident investigation 3. Suicide 6 ☐ Could not be	(Month, Day Year) Injury unk • u	nk⊌ 1 □ Yes 2 🛣 No	u	ınk.
after deatl Director: d in by the	ertifi	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury · At home, farm, s building, etc. (Specify)		28f. Location (Stree City or Town, S	
within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) Certifying Phy	sician: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.	ith occurred at the time, date and plac	e, and due to the caus	e(s) and manner as stated.
To the complet	Me	29b. Signature and title of certifier	Pmi	29c. License number 50791	29d.	Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2004 05938 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February **Physician** Jose F. Bernal 2004 11:38 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Pay, Year) Aug 18, 1951 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** EI Salvador 12 M 2□ F 219-19-9249 52 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c City Town or Location 10a, State 10b. County rai', or items 23a or 28e-f show Examiner must be notified at 1 X Yes 2 ☐ No Wheaton Maryland Montgomery Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12053 Milton Street 20802 **USA** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 Specify: Salvadorian 1⊠ Yes 2□ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Custodian Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic avant, 90ce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jose S. Bernal Dominga Guardado 19a. Informant's Name/Relationship (Type, Print)
Maura Bernal (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12053 Milton Street, Wheaton MD 20802 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 MRemoval from State Janitos Cemetery 2/14/2004 San Miquel, El Salvador 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of uneral Service Licensee 9013 Annapolis Road, Lanham MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. As only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ventricular T achycardia Physician /Medical Due to (or as a consequence of): Examiner Acute myocardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Hypertension 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 ☐ Yes 2 PNo or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 3 DOA 2 ER/Outpatient Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospitel teritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D32817 February 8, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M-wajeed Khan, M.D. 12016 Georgia Avenue, Wheaton MD 20802 31. Date filed (Month, Day, Year)
FFR 0 9 2004 32. Registrar's Signature State 09 FEB Registrar

DHMH 17 Rev 1/200

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		•	For State Registrar	State of Maryland		rtment of H tificate of I			ene 2	004	05939
A. 78	· ·		Decedent's Name (First, Middle, Last)					2. Date of Death	1	Year (3. Time of Death
	Physicia		Charles Richard	Bvnaker				February	Day 7,	2004	5:04A M
	/Medic Examin		4a. Facility Name (If not institution, give sta			4b. City, Town, or	Location of Death		4c. Cour	nty of Death	
			Doctor's Community	Hospital		Lanham			Pri	nce Geo	orge's
.38°.	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. In		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpla Countr	ace (State or Foreign
	Director		577-26-5167	M 2□F 81	Yrs.			May 1,	1922	Virgi	nia
5	2	1	Usual Residence of Decedent 10a, State 10b. County	10c. City	, Town or Lo	cation				10	d. Inside City Limits
alvie	sho sho	5									1X Yes 2 □ No
Mad	or 28a-f show	Director	Florida Flagler	Pa	1m Coa	S t 10f. Zip Code		10	On Citizen o	of What Countr	N7
, di	10.0		100 Bridgehaven D:	rivo		3213	7		U.S.A		.,.
die	18 23	era		2. Was Decedent Ever in U.S	S 13 V					ace - America	n Indian,
d Z I Z I J-0030 filed within 70 hours after death with the Maryland	s i and 2 should be lied within 1.2 hours arise destit with the maryar item 2.7 is marked other than "natural", or items 2.3a or 28a-1 should have a shown than "natural", or items 2.3a or 28a-1 shown other traumatic event, the Medical Examitrational be confilled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWI]		Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)		lack, White, e	tc.
5 3	atura	ed	15. Decedent's Educa	ation	16a. Deced	lent's Usual Occup	ation		6b. Kind of	Business/Indu	ustry
7 2	V C	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	kind of work done o DO NOT use retired	during most of work ()	ang			
7	Hygiene Sthar the ent, the	Eo	7	College (1-401 34)	Maint	enance E	ngineer		ARA D	istric	t News
3	mould be lifed withing Marked other than marked other than imatic event, the Marked by	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ө (First, Middle, M	fa <i>iden S</i> um	ame)	
9	ould be Mental harked o	ToB	Charles William By	ynaker			Claira	May Roof			
ב ק	and M ls mar aumat		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street	and Number or Rur	al Route Number,	City or Tow	m, State, Zip (Code)
2	alth a 27 ls		Charles J. Bynaker	- Son	1520	Thames 1	Drive, Le	xington,	KY 4	0517	
ย์	of Head		20a. Method of Disposition	C	lace of Dispo	sition (Name of natory or other place		Date 2	20c. Location	n - City or Tow	vn, State
			1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	Met	ropol:	Ltan Crema	tory 2/8/	2004	Alexar	ndria,	Virginia
	artm orts inju		21. Signature of Funeral Service bicense	,2			ss of Facility Ga				
	Deparent Impo		It Constance	e Dusch	4	739 Balt:	imore Ave	., Hyatt	svill	e, MD 2	20781
, P	hysician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death a cause on each line.	n. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	Jence of):	CHEL	•		4		Jasea
	Examiner	_	Sequentially list conditions, b.	Due to (or as a consequ	21/1/	IN F	MOLLES	2012	0		Cia/3
3	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	Jerice or):	1000	1. 7	- 1	1-7	-	8000
	and -tran	хап	that initiated events c.	Due to (or as a consequ	ience of):	ser or	gen	asas	2020	1	/ EC(13
, 0	cate be xecuted physicial and the bural-transit			(- (-	- 4 18 1	1 18	Tree	disca	1 0		TENIS
2/00	physi the t	dicai	d.	- 60:0	V/210	7 11	17 6	LUJET.	3.0		
×	w requires that the death certificate be been signed by the attending physicial should be detached for use as the bur	/Me	IF FEMALE: 23	lc. If yes, outcome of pregna	ncv				334 [Date of deliver	
ž p	death c	ician/Me	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other <i>(specify)</i>					y Day Year
o i	the de	hysic	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown	sam 5_	Cilial (apacity)					
ı.	requires that the een signed by th hould be detache	Δ.	Part II. Other significant conditions cont	tributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use co	ontribute to the	a cause of death?
ds,	sign d be	d by						1 □ Ye	s 2 🗷 No	3 🗀 Proba	ibly 4 □Unknown
ecord	requ been shoul	ompleted						24a. Was ar	241	h Wara auton	sy findings available
ě	ela has je 2	m						autopsy	/	prior to com death?	pletion of cause of
		O						1 ☐ Yes 2		1 Yes	2 □ No
	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		Oth	00	th (Check only one			
ō 8	Physical distribution	<u>۲.</u>	1 Yes 2 No 27. Manner of Death	1 ☑ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time of	T 3 DOA	4 Nursing H	ome 5 Reside			
ב	ding f	ion	1 Matural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No		, , ,		
DIVISION	Attendii death. ctor: A y the fu	ical	3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, str			28f. Location (Str	eet and Nu	mber or Rural	Route Number,
	al or Attend after death Director: d in by the	Certification:	4 Homicide determined	building, etc. (Specify	r)			City or Town	, State)		
-	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 ☐ Certifying Phys	ician: To the best of my kno	wiedge, deatl	occurred at the tir	ne, date and place.	and due to the ca	use(s) and	manner as sta	ated.
:	a Hoi 24 h a Fur etely	edicai		er: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	pinion, death occur	red at the time, da	ite and plac	e, and due to	the cause(s)
	Vithin ormple	Me	29b. Signature and title of certifier	01		29c. Licens	e number	25	d. Date sig	ned (Month, D	Day, Year)
, '	->-0		A-5	raugh		1)	-1754	io	2,	7,00	-/
	6/11/		30. Name and address of person who cor	mpleted cause of death (Item	1 23a) (Type.	Print)				1/-	
ار	10/1/0	1	Asghar Shaigan	71720	napol	is Road	Sute 12	L Blader	sbur	g, mai	ryland
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	81					
	Dogiot	10F :	CCD 0 9 2004	Blacker Jo	14						

			For State Registrar	State of Maryl	and / Depa	artment of H	ealth and N Death		giene Reg. No.	2001	+ 05940
3.	Physicia	an	1. Decedent's Name (First, Middle, Last) Virginia Mae Bea	n				2. Date of De Month	Day	Year Y XXX	3. Time of Death 3. OD AM
4	/Medic		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death		_/_	county of Dee	
	Examin	er	Doctor's Community			Lanha	m		Pr	ince G	eorge's
_د.	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9. Bir	thplace (State or Foreign
	Director		267 - 34 - 4032	M 2DXF	84 Yrs.	Worth's Days	710073	Sept. 1	6, 19	19 Ma	ryĺand
	p ,	0	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ocation					10d. Inside City Limits
	anyla	7	Maryland Prince Ge		Bow						1 XYes 2 No
	r 28a-f show	ect	10e. Street and Number	orge s	DOW	10f. Zip Code			10g. Citiz	en of What Co	ountry?
	23a or	ᅙ	12319 Stonehaven	Lane, T-11			715		U.S	.A.	
	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show the Medical Examiner must be neutified at	Funeral Director		2 Was Decedent Ever	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No)- 1	4. Race - Ame Black, Whi	
4 0	after dea or Items	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ŽÎNo If Yes, Give			Specify:	o riican, etc.)	- 1	Specify:	19, 910.
KG/N// 21215-0036	ral', c	d by	3 Widowed 4 □ Divorced	Year or Dates:						W.	hite
5.6	72 h natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wor	king	16b. Kin	d of Business	/Industry
3 5	within ane.	du	Elementary/Secondary (0-12)	College (1-4or 5+)		erk	,		Reta	il Foo	d Sales
× 20	filed v Hygie other i	ပိ	17. Father's Name (First, Middle, Last)		01	CIR	18. Mother's Nan	ne (First, Middle			a bares
an	d be antai	To Be	· · · · · · · · · · · · · · · · · · ·	reenfield	Vermill	ion	Eva P	earl Ha	111		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mentat Hygiene. Important: if item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa once.	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ing Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State,	Zip Code)
	and 2 Balth a n 27 Is		Linda F. Luers - N	iece	8317	Cowan Av	enue, Bo	wie, MD	207		
Z.	as 1 a of He of He itam		20a. Method of Disposition 1 Buriat 2 □ Cremation 3 □ Re		b. Place of Disponentery, cre	osition (Name of matory or other plac	e)	Date	20c. Loc	ation - City or	Town, State
€ E	Page nent ant: It		*4 □Donation 5 □ Other (Specify)	I		Church Ceme					le, Maryland
ຶ່ງພາ Baltimore,	permit. Departr Imports eny inj		21. Signature of Funeral Service License	ю //	1 2	2. Name and Addres				1 Home	, P.A.
	207 2 2 3		A Conslan	re Jas		739 Balti	more Ave	nue, Hya	ittsv	ille, l	MD 20781 Approximate
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	death. Do not en	iter the mode of dyin	more Aveg, such as cardiac	or respiratory a	rrest,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Con	gestive	Heav	t tail	uve =			3 weeks
1	/Medical Examiner		ſ	Due to (or as a cor	nsequence of):		100%	مالا حز			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):	. 1	ALM	927			
	ate be executed thysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			Jan Jan	55	, .			
ó	be executed ician and burial-transit		resulting in death) Last	Due to (or as a cor	nsequence of):	18	Hr.				
376	ate be nysici he bu	cal									
Box 68760	artifica ing pt a as tl	Physiclan/Med	IF FEMALE:								
ĝ	eath certific attending p for use as	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr 1□Live birth 2□	Fetal death 3	□Ectopic pregnancy	,		2	3d. Date of de Month	elivery Day Year
o.	the a	sic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)					
P.O.	es that the de gned by the be detached	Ph	Part II. Other significant conditions con	tributing to death but no	t resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute t	to the cause of death?
ds,	uires l signe Id be	d by	Hip trac	ture				1 🗆	Yes 2]No 3□P	robably 4 🖾 Unknown
Ö	w requir been s should	lete						24a. Was		24b. Were a	utopsy findings available
B	The lar	Completed							psy ormed? 22No	prior to death?	utopsy findings available completion of cause of
<u>ra</u>	ician: Th certificate ector, pag	Be C	25. Was case referred to medical			-	26. Place of Dea	1 ☐ Yes ath (Check only	_		20110
Division of Vital Records,	ding Physician: n. After this certific funeral director,	To B	evaminer?	lospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Oth	00	lome 5 ☐ Res	idence 6		
0	ding Phon. After thi funeral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time	Wor	y at k?	28d. Describe	how injury	occurred G	ETTING UP UNSTEADY
<u></u>	ttandir death. ctor: Af y the fu	Certification:	2 Accident investigation	2/1/0	4 7:00	PM 10	Yes 2 No	GAITTI	SALAR	CE.	
. <u>≥</u>	if or Attand after death Diractor:	THE STATE OF	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (S	pecify)	treet, factory, office		City or To	wn, State)		Rural Route Number,
٥	ital curs af			HOSPITAL				8/18		-	N M D 70704
	To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier Certifying Physical Check only Medical Exemination	sicien: To the best of my ner: On the basis of exa and manner stated.	y knowledge, dea imination and/or i	nvestigation, in my c	pinion, death occu	e, and due to the urred at the time	date and	place, and du	e to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	1/1 -		29c. Licens	e number		29d. Date	signed (Mon	oth, Day, Year)
	F 3 F 8			U	3 mm	0-	358	04	-7	451	C4
A A	(20)		30. Name and address of person who co	empleted cause of death	(Item 23a) (Type	, Print)					
CA			Peter Edding	M.O. 1434	Callan	ose La	~ # (10	(50 W)	Œ,	an	
	Sta	ate	31. Date filed (Month, Day, Year)	22. Registrar's	Signature	de					

State of Maryland / Department of Health and Mental Hygiene 05941 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 8:30 P M 2 2004 CLARENCE BARNES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10109 Balsamwood Drive Laurel Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Yrs. 82 242-18-6145 05/08/1921 Director Virginia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location in than "naturel", or items 23a or 28a-f show the Modical Examiner must be notified at 1€ Yes 2 No MD Director Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10109 Balsamwood Drive 20708 United States by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Bleck, White, etc. filed within 72 hours after 1 Never Married 253 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 E No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If Item 27 is marked other ti
any injury or other traumatic event, IIIs
once. Electrical Engineer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eliza Cosby Clarence W.T. Barnes Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10109 Balsamwood Dr. Laurel, MD 20708 Carrol Barnes/ Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Riverdale Crematory Riverdale, MD * 4 Donation 5 Other (Specify) 2/12/04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiomyopathy /Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical as the the attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has funeral director, page 2 autopsy performed? certificate 1 Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 💯 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 🔁 Natural death. 1 Yes 2 No 2 Accident 4 hours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifie (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and D25430 02/09/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 John Margolis M.D. 13952 Baltimore Ave. Laurel, MD 20707 31. Date filed (Month, Day, Year) State 10 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1 - For State Registrar 05942 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 3:45 P ANNE BERGOFFEN GERTRUDE **JANUARY** 31, 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner VANTAGE HOUSE COLUMBIA HOWARD 8. Date of Birth (Month, Day, Y JULY 13, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1□M 2√F 1910 CONNECTICUT 230-50-9764 93 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other treumatic event, the Medical Examinar must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√ No MD HOWARD COLUMBIA Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5400 VANTAGE POINT ROAD 21044 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL TEACHER PUBLIC SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEON J. SCHAFF SARAH GLUCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GENE BERGOFFEN - SON 87 RAPPUTAK, FRYEBURG, MAINE 04037 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
21. Signature of Ferroral Service Trees KING DAVID CEMETERY | 02/15/2004 FALLS CHURCH, VA 22. Name and Address of Facility NATIONAL FUNERAL HOME 7482 LEE HIGHWAY, FALLS CHURCH, VIRGINIA 22042 23a. Part 1. Enler the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA Physician WEEKS /Medical Due to (or as a consequence of) Examiner PROGRESSIVE DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Wes decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🛣 No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> COPD 1 Yes 2 No 3 Probably 4 ™Unknown pleted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Comi 1 ☐ Yes 2 ☐ No 1 Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No ို this 28a. Date of Injury (Month, Day Year) Director: After the 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural Injury 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hosping within 24 hours after To the Funeral Dir 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D-34868 land FEBRUARY 9, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. DIENER, M.D. 11055 LITTLE PATUXENT PARKWAY, COLUMBIA, MD 21044 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 1 0 2004 Registrar

DHMH 17 Rev 1/2001

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State of Maryland / D	Department of Health and I	Mental Hygiene 2004	059
	Certificate of Death	Reg. No.	
1		2 Date of Death	2 Time of F

			1 - For State Registrar		State of Ivid	агушна <i>г Бер</i> Се	rtificate of l	Death		leg. No.	4 05941
	Dhunisi		Decedent's Name (First	t, Middle, Last)					2. Date of Dea Month		3. Time of Death
d,	Physici /Medic		EVE			LANTON				30,2004	9:45pm M
1	Examin	er	4a. Facility Name (If not in				4b. City, Town, or Kensingt	r Location of Death		4c. County of De	
			Kensington 5. Social Security Number			e (In yrs. last birthday		If Under 24 Hrs.	8 Date of Birth		
	Funeral Director			1 🗆	м 2XD F / ^9	72 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country) W. Virginia
Н			253-40-2452 Usual Residence of Dece			12			rebluar	y 1,1241	v. viiginia
	how		10a. State 10b.	County		10c. City, Town or L	ocation				10d. Inside City Limits
	e Ma	cto	Md. Mo	ntgomei	сy	Kensing	ton				1 ☐ Yes 2 ☐ No
	ih th	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
	ath w	rai	3105 Drumm				20895			U.S.A.	
	er de	nue	11. Marital Status		12. Was Decedent Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Al Black, W	nencan Indian, hite, etc.
36	rs aft	y F	1 Never Married 2 3 Widowed 4 □ D		1 ☐ Yes 21211 If Yes, Give Year or Dates:	NO	1 □ Yes 2 🗓 🖟	Specify:		Specify: .	Black
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show ship injury or other traumatic event, Ira Medical Examinar must be profiled at ances.	Completed by Funeral	15. D	ecedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busine	
215	nin 72	piet	(Specify onli Elementary/Secondary	y highest grad	e completed) College (1-4or 5	(Give	dent's Usual Occup: kind of work done of DO NOT use retired	during most of work d)	ing		•
212	d with	E	Elementary/Secondary	(0-12)	2yrs	Soci	al Worker			Private	
b	be filed ital Hygie d other event, t	3e C	17. Father's Name (First,	Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surname)	
la	should b nd Menti marked umatice	To Be	William Don	ald Bla	anton			Effie Ch	napman		
Maryland	2 shc and ls m		19a. Informant's Name/R	elationship (Ty	rpe, Print)					r, City or Town, State	, Zip Code)
	and lealth m 27		Christopher		on/Son	3105 20b. Place of Disp	Drumm Ct		ngton, M		T State
Baltimore,	Pages 1 nent of H int: If Ite		20a. Method of Dispositio 1 ☑ Burial 2 ☐ Cree	mation 3 🗆 P	Removal from State	cemetery, cre	matory`or other plac	(e)		20c. Location - City	
Ë	tmen tant: jury		`4 Donation 5 □C			Harmony		2/5/04		andover,	
Bal	Departing Department of the contract of the co		21. Signature of Funeral	Service Licens	To A	Š	2. Name and Addres	. 30		Jenkins	
	X-1		23a. Part1. Enter the dis-	ease or omol	ications that caused					. D.C. 20	Approximate
			shock, or heart failu Immediate Cause (Final	re. List only of	ne cause on each lii	16					Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)		a	nemic	CRY	elora	1 378	VICE	
	Examiner				L	112ev te	nsion)			
	*	ē	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	ns, ate	Due to (or as	a consequence of):	, , , , , , ,				
	ificate be executed g physicien and as the burial-transit	Examiner	Cause (Disease or injury that initiated events	1	c.						
ó	tificate be executed g physicien and as the burial-transit	Exa	resulting in death) Last		Due to (or as	a consequence of):					
68760,	ite be iysicii iye bu	edical			d						
	rtifica ng pt		IF FEMALE:								1
Вох	death cer e attendir id for use	an/	23b. Was decedent preg	nanı		2 Fetel death 3	☐Ectopic pregnancy	,		23d. Date of o	delivery Day Year
	the al	Physician/N	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	13:	4□Pregnant at 9□Unknown	time of death 5	Other (specify)				34,
P.0	requires that the death cert een signed by the attendin hould be detached for use	P	Part II. Other significant	conditions co	ntributing to death b	ut not resulting in the	Inderiving cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
JS,	signe d be d	l by	Turini emor eiginieum		inibating to doubt b		moonying seaso give		1 🗆 Y	1	Probably 4 □Unknown
Ö	v require been si should l	Completed							240 1450		autorou findina aurulahla
3ec	The law ite has b bage 2 st	mpi							24a. Was a autops perfor	sy prior t	autopsy findings available o completion of cause of ?
Vital Records,			OS Man anna ratarrad ta	disal				00.51	1 Yes	200 No 1 □ Y	
₹	Physician: this certific ral director,	o Be	25. Was case referred to examiner? 1 Yes 2 No		Hospital:	ent 2 ER/Outpatie	nt 30 DOA Oth	90. Place of Deat		ne) ence 6 □Other (S _i	
o	Phy or this oral d	. To	27. Manper of Death		28a. Date of Inju (Month, Da					ow injury occurred	эвспу)
lo	Attending Ir death. ector: After	ation	1 Natural 5 ☐ 2 ☐ Accident	Pending investigation	(Month, Da	y Year) Injury		K? Yes 2 □No			
Division	Attendi ir death. ector: A by the fu	Hice		Could not be determined	28e. Place of Inj	ury - At home, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and Number or	Rural Route Number,
Ö	s afte	Cert			bullang, or	o. (open,y)			Only or Ton	, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Certification;	29a. Certifier (Check only 2	Certifying Phy Medical Exami	sicien: To the best	of my knowledge, dea f examination and/or in	th occurred at the tin	ne, date and place,	and due to the c	ause(s) and manner	as stated.
	the F the F nplete	Medi	one)		and manner st	ated.					
	To To To To To To To To To To To To To T	2	29b. Signature and title o	r certifier	1/1/2	can/a	29c. Licens	0058		29d. Date signed (Mo	4 1
0	(2)		Pour.	TYG	1000	7			03 1	ennary	, 2007
K	(2)		30. Name and address of			leath (Item 23a) (Type	Print) SAI	MAPU	CKVIL	ACAM	MD . 20057
	Ü		11112	CCKV	ILLE V	1100,5	10 10	U, NUC	LKVIL	LE : 1VII	1 60076

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
FEB 1 1 2004



05945

			1 - For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of H rtificate of I	lealth and Death	Mental Hy	giene 2004 Reg. No.	05946
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last,	Britt		4b. City, Town, o	r Location of Dea	2. Date of De Month Feb.	Day Year 4 200 4 4c. County of Death	3. Time of Death
	Funeral Director	e,	Clinton Nursing & 5. Social Security Number 579–26–9652		er s. last birthday) 86 Yrs.	Clinto If Under 1 Year Months Days			Prince Ge th ay, Year) 1917 Earl	eorges place (State or Foreign untry) y Branch, S.
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge		City, Town or Lo					10d. Inside City Limits 1 ☐¥es 2 ☐ No
	th with the 23e or 28e ast be noti	Funeral Director	10e. Street and Number 9211 Stuart Ln.			10f. Zip Code 20735			10g. Citizen of What Col United State	•
036	within 72 hours after death with the Maryland sne. than "natural", or Items 23e or 28e-f show the Mailcal Exe. interf. ast be neithed at	b	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🌣 No If Yes, Give Year or Dates:	'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2점 No	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	o- 14. Race - Amer Black, White Specify: B1a	e, etc.
21215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Items 23s or 28e-f show evant, The Madical Estroiner and be recified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired borer	during most of wa	orking	16b. Kind of Business/I	
Maryland 2	should be filed ind Mental Hygi marked other umatic evant, II	To Be C	17. Father's Name (First, Middle, Last) Christopher Sande				Eliza	beth Wal		
	nd 2 state at trau		19a. Informant's Name/Relationship (Ty Judy Britt / Daug		19b. Mailir 3420			mple Hil	er, City or Town, State, Z. 1s, Md. 20	ip Code) 748
Baltimore,	permit. Pages 1 a Department of Hea Important: If Item any injury or otha		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	lemoval from State	Harmon	sition (Name of matory or other place y Memoria	1 Feb.		20c. Location - City or T Landover, M	
Bai	permit Depar Impor any ir		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complete	c ~61085					l Homes Eville, Md.	20747
58760,	Cate be executed hysician and bhysician and physician and the purial-transit street burial-transit	dical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.) Due to (or as a consect.)	tage equence(of):	Heart Renal Mellit	Failus Dise	ze ease		Interval Between Onset and Death
P.O. Box 6	death certiff e attending ed for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 □	Ectopic pregnancy		1, , , 14 1, , , ,	23d. Date of delik Month	very Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions con	ntributing to death but not re	esulting in the ur	nderlying cause give	en in Part I.		obacco use contribute to Yes 2 ☑No 3 ☐ Pro	the cause of death?
Division of Vital Records,	The ate has page	Completed						24a. Was autor perfo 1 🗆 Yes		opsy findings available ompletion of cause of
of Vit	ding Physician: 1 h. After this certifical funeral director, p	To Be	TI THE ZUZINO		☐ ER/Outpatien		er: 4½ Nursing I	ath <i>(Check only c</i> Home 5 ☐ Resid	one) dence 6 □Other (Spec	ify)
ion	ding After fune	atlon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	/at <br Yes 2 ☐ No	28d. Describe	how injury occurred	
Divis	To the Hospital or Attanding within 24 hours efter death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (City or Tox	Street and Number or Rui wn, State)	al Route Number,
	ns Hospital n 24 hours e ne Funeral i pletely filled	Medical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my ki ner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	n occurred at the time vestigation, in my of	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the I	Σ	29b. Signature and title of certifier	10		29c. License			29d. Date signed (Month)	
2	(3)		30 Name and address of person who so	empleted gause of death (Its	ет 23a) (Туре, Д. Д.	Print) 1328 S	pouther	n Ave	February J. SE, Was	1.DC20032
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 2 2004	82. Registrar's Sign	nature	E .	-			

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician BURTON 4:20 A M February 11 CLARENCE В. 2004 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 19, 1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1⊠M 2□ F 85 241-16-2954 Aulander, N.C. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1K Yes 2 No Washington, D.C. Directo D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö U.S.A. 20018 3104 Monroe Street, N.E. Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1941 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1⊠Yes 2 □ No If Yes, Give 1 ☐ Never Married 257 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify Specify: Black þ 3 Widowed 4 Divorced Year or Dates "natural", ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complete College (1-4or 5+) 4 Years than Elementary/Secondary (0-12) Il Hygiene. U.S. Postal Services Postal Service Administrator permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othe any injury or other traumatic event, since. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lilly Lassiter Zedrick Burden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby D. Burton/Wife 3104 Monroe St., N.E., Washington, D.C. 20018 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico National Ceme. 2/19/04 Triangle, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FORT LINCOLN FUNERAL HOME Nancy 3401 Bladensburg Road, Brentwood, Maryland 20722 23a. Part1. Enter the chease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Terminal Dementia /Medical Due to (or as a consequence of) **Examiner** Dehydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Electrolyte Disturbances physician ar s the burial-ti Due to (or as a consequence of): Box 68760 ician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a Ö Physi 9 Unknown 9 Unknown Division of Vital Records. P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 28 No 1 Yes 2 No 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ို 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA : After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending s after deau. 1 🔀 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🔲 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funerel C the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060380 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Candice Geronimo Silvestre, M.D., 110 Irving Street., GB-10, Washington, DC 20010 31. Date filed (Month, Day, Year) State FEB 1 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05948 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Feb. 10, 2004 Year Arenta Petronella Biggs 7:35 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** National Lutheran Home Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov. 19, 1907 **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 ☑ F 225-70-0626 96 Director Washington, D. C. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location r 28a-f show inotified at 10d. Inside City Limits Maryland Montgomery Rockville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a.or the Medical Examiner must be 9701 Veirs Drive 20850 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0036
mut. Pages 1 and 2 should be filed within 72 hours after of a riment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural, or Item any injury or other traumatic event, the Medical Examinations. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Johannes Christian Rasmussen Susie Blanche Cook 19a. Informant's Name/Relationship (Type, Print)Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilma Christine Garvey 19359 Frenchton Place, Montgomery Village, Md. 20886 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Feb.13,2004 Arlington, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) Columbia Gardens 22. Name and Address of Facility Murphy Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4510 Wilson Blvd., Arlington, Virginia 22203 23a. i art 1. Enter the disease, or or plic tions that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonio /Medical Due to (or as a consequence of): Examiner Melviers Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? 2□ No 1 Yes 2 No 1 Tyes Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certific dompletely filled in by the funeral director. 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death Check onl. one Hospital: Other: 1 ☐ Yes 2 ☐ No 1 Inpatient Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Februrary ress of person who completed cause of death (Item 23a) (Type, Print) Germantoan. 19500 Doniel Jaller up Amaranth Drive 31. Date filed (Month, Day, Year) FEB 1 2 2004 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 05949 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Year Alexander Browne Blair, Jr. 2/3/2004 6:15 p M /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Deeth 2000 Baltimore Road, Apt A-34 Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1⊠M 2□F 70 Director 579-40-6026 7/24/1933 Washington, DC Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show Examiner must be notified at Montgomery Rockville 1x Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2000 Baltimore Road, Apt A-34 20851 U.S.A. Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates: Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Chief U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alexander Browne Blair ျှ Nancy Sutherland Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nannie May Blair - Wife 2000 Baltimore Road, Apt A-34, Rockville, MD 20851 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2/6/2004 Metropolitan Crematory * 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. tonstance 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final disease or condition Diabetes **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Atrial Fibrillation Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine transit The law requires that the death certificate be executed Pneumonia 1 month and burial-t Due to (or as a consequence of): Box 68760, attending physicien for use as the buria Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No signed by the a o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy 1 ☐ Yes Division of Vital 2 € No Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 🔀 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours aft • Funeral Di letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) ME88648 (FL) 2/6/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Internal Medicine, National Naval David Brett-Major, M.D. Medical Center, 8901 Wisconsin Ave., Bethesda, MD 20889 31. Date filed (Month, Day, Year) . Registrar's Signature State 1 3 2004 Registrar

Physic		Decedent's Name (First, Middle, La CONSTANCE JU	•				2. Date of Dea Month FEB	Day	Year 2004	3. Time of Dea
/Medi Examii		4a. Fecility Name (If not institution, given MEMORIAL HOS	re street and number)		4b. City, Town, or	r Location of Death	1.00	4c. Cour	ty of Death	16:25
uneral irector			Sex 7. Age (In yrs. Ia: 1□ M 2 F 85	yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day MARCH 8	Year) 1918	9. Birthp Coun PENN	lace (State or Fo try) SYLVANI
a-f show	ctor	10a. State 10b. County MARYLAND ALLEGA		Town or Loca					10	0d. Inside City Li
a or 28 be no	Dire	10e. Street and Number	CHLIAN		10f. Zip Code	0.0	1	l0g. Citizen o		try?
, or iteme 23 rardinar musi	by Funeral Director	913 NATIONAL HI 11. Marital Status 1 Never Married 2 🕅 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑No If Yes, Give	lf `	215 as Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	BI	ace - America ack, White, e	etc.
item 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, the Mudical Exercit at marked by political at	Completed b	15. Decedent's E (Specify only highest gr Elementary Secondary (0-12)	Year or Dates: ducation ade completed) College (1-4or 5+)			ation during most of works l)	ing	16b. Kind of SELF EI	MPLOYE	ustry
7 is marked other than "traumatic event, the Mu-	To Be Co	+3 17. Father's Name (First, Middle, Last EDWARD J. THO	MAS	BEAU	JTICIAN	18. Mother's Name			Y SHOP	
item 27 Is m other traum		19a. Informant's Name/Relationship (WILLIAM BERKLEY 20a. Method of Disposition	/ HUSBAND	913	NATIONA	L HIGHWAY	, LaVAL		21502	
Important: If item 27 any injury or other troons.		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Special Service Lice)	THE	CUMBE!	RLAND CR	EMATORY 1		CUMBER	LAND, MAIN	
_ 4 0		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death.	SOV Do not enter	VERS FUN	ERAL HOME	, P.A.	FROST		MD 2153 Approximate
sician and miner transit to price pr	icai Examiner	disease or condition resulting in death) Sequentially list conditions, list any leading to thin ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Aspiration Due to (or as a consequence) Due to for as a monsequence Due to (or as a consequence) d.	nce of):	nia				3	-days
by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deal	eath 3 □Ed	ctopic pregnancy hther (specify)				ate of deliver onth [y Day Year
en signed buld be de	by	Part II. Other significant conditions of Cerebrovascular a		ing in the unde	erlying cause give	n in Part I,		acco use con		cause of death
certificate has be rector, page 2 sho	Completed						24a. Was ar autopsy perform 1 Yes 2	ned?	Were autopoprior to comdeath?	sy findings avail pletion of cause
fter this neral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 No Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28	NOutpatient 8b. Time of Injury	3 DOA Othe	at 2		nce 6 🗆 Otl		
한 든	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street	, factory, office	2	8f. Location (Str City or Town	eet and Numi , State)	ber or Rural	Route Number,
ral Director: A led in by the fu	60	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death or n and/or inves	ccurred at the time tigation, in my op	e, date and place, a inion, death occurre	nd due to the ca d at the time, da	use(s) and m ite and place,	anner as star and due to t	ted. he cause(s)
e Funeral Direc letely filled in by	dic	OH M								
To the Funeral Direct completely filled in by	Medical	29b. Signature and title of collifier	0		29c. License	1486T		EB.	ed (Month, D.	ay, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** Compton Mary February 8, 2004 3:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Nursing Center Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 21 F Months Days 84 12/14/1919 **Director** 213-12-9654 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth end Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23e or 28e-f show eny injury or other traumatic event, it is Medical Evainment. Author Influed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Allegany Corriganville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number P.O. Box 193 (Diamond Lane) USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Bookkeeper Automotive Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Earl Martin Julia Naomi Lapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Waltman / daughter P.O. Box 344, Ellerslie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 02/11/2004 Cumberland, MD 21. Signature of Fluneral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21502 404 Decatur Street, Cumberland, MD alu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner page 2 should be detached for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Records, P.O. Box 68760 Physiclan/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Tes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 24 hours after death. 1 Matural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical of. Combeland, old completed cause of death (Item 23a) (Type, Printy) nas HA LMOS

State

Registrar

Year)

2004

32. Registrar's Signature

		1	For Stete Registrar	State of Maryland		rtment of He tificate of D			ene 2004	05952
			Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		CLARENCE (ARPONTER				Month	8 04	3:30 PM
	Examin		a. Facility Name (If not institution, giv			4b. City, Town, or L		1	4c. County of Deat	
		· k	HOWARD CO. GEA			Cohume	If Under 24 Hrs.	O Date of Birth	HOWER	
*	Funeral	1	5. Social Security Number 6. S	ØM 2□E	Vre	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,)	rear) Co	hplace (State or Foreign untry)
	Director	-	214-76-6130 Usual Residence of Decedent	8	3			eptember	29, 1920	Mararano
	/land	-	10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Man	to	Maryland Howar	d <u>c</u>	olumb:	ia				1 ☐ Yes 2 ☐ No
	th the	lrec	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Co	untry?
	23a	la	9359 Torrent Row			21045			U.S.A.	i Indian
	tema tema	Funeral Directo	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	13.	Was Decedent of His f Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 🙀 No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or teems 23s or 28s-f show hedical Esartimer runal be notitied at	pe	15. Decedent's E	ducation	16a. Deced	dent's Usual Occupat	ion		6b. Kind of Business	Industry
212	nin 72 na" na	ple	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done du DO NOT use retired)	iring most or work	ng		
21;	d with	Completed	3		None					
nd	sal Hygir d other	Be	17. Father's Name (First, Middle, Last					(First, Middle, Ma		
yla	should be and Mental marked o	မ	Clarence Daniel		405 Mailie	a Address (Ctroat o		ms Carpe	City or Town, State, 2	Zin Code)
Maryland	C (0 m		19a. Informant's Name/Relationship (Clarence Daniel C			ypress Pla	ane Tudi	beett ee	MD 2064	n
	1 and 2 Health tem 27 l		20a. Method of Disposition			sition (Name of natory or other place	, #.1 ·	Date 11	oc. Location - City or 004 Pomfret	Town, State
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Baltimore,	permit. Pages Department of Inportant: If ite any injury or of		21. Signature of Funeral Service Lice		_				neral Hom	
B	Depa Impo any ir		males the						Head, MD	
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Ž.	Examiner	_	Sequentially list conditions,	. UPINARY	00000000	RACT I	NIFEC	ION		24 MOUR
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequ	ence on.					
	be executed Ician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):					
8760	cate be executed physician and the burial-transit	Ical		d						
9	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	9								
Box	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of de Month	livery Day Year
	e deal	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of de 9□Unknown	ath 5	Other (specify)				
P.0	that the de led by the a detached	Phy	9 ☐ Unknown Part II. Other significent conditions	contributing to death but not resu	tting in the u	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds,	ires tha signed	þ	CANCER	OF THE		ARYN	X	1 🗆 Yes	2 □ No 3 □ P	robably 4 Unknown
Orc	w requir been si should	etec	DIABETES	MELLITU	<			24a. Was an	24b. Were a	utopsy findings available
Records,	The law ate has page 2:	Completed	UNTOFIES	TILLETTO				autopsy	ed? prior to death?	completion of cause of
a		ပိ	25. Was case referred to medical	IV.			26. Place of Deat	1 Yes 2 h Check on one		2 2 140
Vital	Physician: this certificanal director,	0 8	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 🔼	FR/Outpatie	nt 3 DOA Othe	r: 4 ☐ Nursing Ho	me 5 Resider	nce 6 Other (Spe	early)
Jor		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury Work	at ?	28d. Describe how	w injury occurred	
sior	uttendin death. ctor: Af y the fur	atlc	2 Accident investigation	h.			/es 2□No			10 11
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	Hospital c 24 hours af Funeral D itely filled in		29a. Certifier 1X Certifying F	Physicien: To the best of my know	wladna das	h occurred at the time	e, date and place	and due to the ca	use(s) and manner a	s stated.
	24 hos Fun etely	Medical	(Check only 2 Medical Ext	aminer: On the basis of examinat and manner stated.	ion and/or in	nvestigation, in my op	inion, death occur	red at the time, da	te and place, and du	e to the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certifier	Λ Λ		29c. License	number	29	d. Date signed (Mon	th, Day, Year)
	. ,,,		1 1 Marcher	Marchs	MD	D3	10	F	EBRUAR	4 10,2004
2	nΓ		30. Name and address of person who	o completed cause of death (Item	23а) (Туре	, Print)	5.0			~ ~ ~ ~ ~
1	CCK		W. MDREW I	MARKS ZV	< NOL	LNORTH	DEIVE	Calvi	7151/A M	D 21045
1	St Regist	ate	31. Date filed (Month, Day, Year)	32. Polistrar's Signal	H A	backs				

			1 - For State Registrar	State of Maryland		rtment of He			iene •g. No. 20 (05953
	Physic		Decedent's Name (First, Middle, Last) Calvin Ja	umes Cõ	ovany,	Sr.		2. Date of Dear Month Februar	th Day Ye	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give str 20790 Mercer Ave:	reet and number)	ovarry,	4b. City, Town, or			4c. County of C	eeth
, s	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	OCK Hall If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Dec. 7,	Year) 9.	ent Birthplace (Stete or Foreign Country) ennsylvania
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other then "naturel", or Itams 23a or 28a-1 show other traumatic event, Ita Medical Expirarract state to truffiled at	Completed by Funeral Director	10a. State 10b. County MD Ken 10e. Street and Number 20790 Mercer Ave	enue . Was Decedent Ever in U.S Armed Forces? 1 GYes, Give Year or Dates:	3. 13. V II 16a. Deced (Give	Hall 10f. Zip Code 2166 Vas Decedent of His Yes, specify Cuban Yes 2 XNo ent's Usual Occupation of work done di O NOT use retired) rician/Pl	panic Origin? (Sp., Mexican, Puerto Specify: tion uring most of work	pecify Yes or No- Rican, etc.)	Black, V Specify: 16b. Kind of Busine Magnolia Nursing H	merican Indian, /hite, etc. White ss/Industry Hall
Baltimore, Maryland	permit. Pages 1 and 2 should be f Department of Health and Mental i Important: If item 27 is marked of eny injury or other traumatic eve once.	To Be	Delroy Covany 19a. Informant's Name/Relationship (Type Vernice Maryene Cov 20a. Method of Disposition 1 Burial 2 Cremation 3 Ref 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	vany moval from State 20b. Pla ce Wes	20790 ace of Disposemetery, crem 1ey Ch	g Address (Street ar) Mercer A sition (Name of latory or other place) lape1 Ceme Name and Address	Emma Go Avenue, I etery 2/1 of Facility Ifenbein	Rock Hall Date 13/2004 I & Newna	City or Town, Stat 1, Maryla 20c. Location - City Rock Hall m Funeral	nd 21661 or Town, State Maryland Home, P.A.
8760,	Cate be executed formulation and physician and Examiner functions and Examiner functions and functions are secured for the private function and functions are secured for the function of the	dical Examiner	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequent	Do not ente	or the mode of dying,	, such as cardiac	or respiratory arre	sst,	Approximate Interval Batween Onset and Death
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\$	Sta	to.	30. Name and address of person who com PATRICIC 51 31. Date filed (Month, Day, Year)	pleted cause of death (Item) HOWAHA 32. Registar's Signatu	15	LO SPEE	n ch	estrat	our m	9 51650
13	Sta Registi	•	FFB 11	2004 Distori	J.	Goods				

A	an	Diane Andrea Co					2. Date of Dea Month	Day Year	3. Time of Death
Medic xamin		4a. Facility Name (If not institution, give	street and number)	4	b. City, Town, o	or Location of De	ath	4c. County of De	ath
		Shady Grove Adve			Rockvi			Montgom	ery
neral ector		5. Social Security Number 6. Septing 215-84-5031 Usual Residence of Decedent	7. Age (In yrs. Ia:		If Under 1 Year Months Days				irthplace (State or Fore Country) shington,]
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Iled	to	Maryland Montgom	erv	Olney					1 □ Yes 2 🔯
S LO	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of What (Country?
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eny injury or other traumatic event, it is Mudical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 21X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		es, specify Cub		(Specify Yes or No- erto Rican, etc.)	Black, Wh	ite, etc.
Cal E.	edi	15. Decedent's Edu	cation	16a. Deceder	nt's Usual Occu	pation		16b. Kind of Busines	s/Industry
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atic	2	Carl Zovko					rol Unknow		7.011
Taur		19a. Informant's Name/Relationship (Ty		3				er, City or Town, State,	. ZIP Code)
ther		Michael Corsillo 20a. Method of Disposition)/ Husband 20b. Pla	32U8 ace of Disposit	Prince ion (Name of tory or other pla		Olney, M	20832 20c. Location - City of	or Town, State
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njury F		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 		Souls (Cemeter		2004	Germantow	
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State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** FEBRUARY 6, 12:30P COOPER 2004 SOL SAUL /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner SILVER SPRING MONTGOMERY 1820 TILTON DRIVE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7 Age (In vrs. last hirthday) **Funeral** Months 1 ★ M 2 □ F 054-09-9437 91 Director MAR. 19, 1912 NEW YORK Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 'natural', or Items 23a or 28a-f show the Midical Examiner must be notified at 1 ☐ Yes 2 → No Ö MONTGOMERY SILVER SPRING MARYLAND Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1820 TILTON DRIVE 20902 UNITED STATES OF AMERICA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 X Yes 2 □ No ARMY If Yes, Give 1938-41 Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UNITED STATES GOVERNMENT filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) NAVAL ARCHITECT DEPARTMENT OF NAVY permit. Pages 1 end 2 should be filed wir Department of Health and Mental Hygienn important: if them 27 is marked other than any injury grother treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SAMUEL COOPER MINNIE GOLDENBERG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11612 BOOTJACK COURT, NORTH POTOMAC, MD 20878 JOSHUA D. COOPER - SON injury grather 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MT LEBANON CEMETERY 02/09/04 ADELPHI, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee EDWARD SAGEL FUNERAL DIRECTION: INC 20852 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC SQUAMOUS CELL CARCINOMA 4 MONTHS Physician /Medical Due to (or as a consequence of) Examiner SQUAMOUS CELL CARCINOMA ON TONSIL 3 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown PROSTATE CANCER Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 XNo the Hospital or Attending Physicisn: bin 24 hours after death. the Funeral Director: After this certified 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital evithin 24 hours all To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D35996 FEBRUARY 6, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINDA M. BURRELL, MD, 2730 UNIVERSITY BLVD. W. #400, WHEATON MD 20902 31. Date filed (Month, Day, Year) FEB 0 9 32. Registrar's Signature State acks Registrar

	•	1 - For State Registrar	State of Marylar	nd / Depa	artment of Health and I	Mental Hy	giene Reg. No. 2	004	059	56
Physicia	an	1. Decedent's Name (First, Middle, La EAPL	Rox	CONI	VELLY	2. Date of De	ath Dav	Year 2004	3. Time of De	eath M
/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or Location of Deatl		1	ty of Death	.700	
LXamiii	CI	Shady Grove Adven			Rockville			gomer	v	
Funeral Director		5. Social Security Number 6. S 218-30-3924		. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Da Feb. 3,	h y, Year)		place (State or Fe	oreign
land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation			1	0d. Inside City L	Limits
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ath wi	rai	16700 Riffleford			20878		Jnited			
after death w	Funerai	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. \	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Ra	ace - Americ ack, White,		
be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do other then "natural; or items 23s or 28s-f show event, the Medical Examinar must be notified at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑Yes 2 ☐ No1 95 If Yes, Give Year or Dates: 19		1 ☐ Yes 2 ☑ No Specify:		Spec	்⁄்y: Whit	:e	
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Atthin De.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired)	XIII G				
yidilid Kilk buld be filed with Mental Hygiene srked other the stic event, then		12 17. Father's Name (First, Middle, Last	1	Ston	e Mason	ne (First, Middle,	Constr		n	
m = 0 5	o Be	Harry Connelly			Helen I		Maidell Sullia	ine)		
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T SET TO THE SET OF TH		20a. Method of Disposition 1∑Burial 2 ☐ Cremation 3 ☐	3B 14 81 1 - 1	cemetery, cren	sition (Name of natory or other place)	Date	20c. Location	- City or To	wn, State	
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permit. Peges 1 and 2 should by Depermit. Peges 1 and 2 should by Department of the atilh and Menta Importent: If Item 27 is marked eny injury or other traumatic events.		21. Signature of Funeral Service Lice	Derlet		Name and Address of Facility D East Deer Park				MD 208	377
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oy the dached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown		(, , , , , , , , , , , , , , , , , , ,					
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Attending P or death. ector: Alter I by the funers	ation	1 ≅Natural 5 ☐ Pending 2 ☐ Accident investigatio		Injury	Work? M 1 ☐ Yes 2 ☐ No		. ,			
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To the Hospitel or Attending Physician: To the Hospitel or Attending Physician: So the Funerel Director: After this certification in the funeral director; Completely filled in by the funeral director;	edical	29a. Certifier 1 T Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best of my kni miner: On the basis of examini and manner stated.	owledge, death ation and/or inv	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the or irred at the time,	cause(s) and n date and place	nanner as st , and due to	ated. the cause(s)	
o the vithin o the	Me	29b. Signature and title of certifier	and marker stated.		29c. License number		29d. Date sign	ed (Month,	Day, Year)	
		Dosph Ball	MD		D 53317	-	FEBIUA	tey 9	2004	
				т 23а) (Туре,	Print)					
		JOSPH BELL 162	20 trederick	(KOY)	Print) FZ13 6+ith	eriburg	MO	2087	(
Sta Registr		31. Date filed (Month, Day, Year) FFB 1 2 20	32. Begistrar's Sign	diure &	Sporks	/				

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 4:40 PM 7/f0750 Collins February 200 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Norsny Examiner Sandy Spring Montgomery Rebak Grove CRSKand 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex **Funeral** Min. T0 1909 Days Hours West Virginia 1 K M 2 □ F 94 Director 578 32 8355 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland satment of Health and Mental Hygiene. ortent: if item 27 is marked other than 'natural', or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at a. . 10a. State 10b. County 10c, City, Town or Location 1 ☐ Yes 2 ☑No Brookeville Montgomery Funeral Director Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20833 1712 Pretty Penny Court United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Be Completed by 3 SWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Accountant 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Ann Wacus Mikhail Kalinauskas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14222 Castle Boulevard , Silver Spring, Md. 20904 19a. Informant's Name/Relationship (Type, Print) Janet C. Hill / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If eny injury or Mount Calvary Cem. 2/12/04 Thomas, West Virginia 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Yerr A therosci /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhiated events resulting in death) Last Dua to for as a sonsequence of) Physician/Medical Examiner use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day jo 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 □Unknown Unbar 70515 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2200 1 ☐ Yes 2 ☐ No certificate 1 Yes After this certification, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending 1 Tyes 2 🗆 No death. 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) hours after 4 Homicide within 24 hours af To the Funeral D Pelli To the Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 4 YSICICA D0055694 6,2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALOK MATHUIZ 4000 Obey, ADD Olsey-Leytorsville 50833 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 09 Registrar

*		For State of Marylai Registra MEND#26perMD2/9/04, BMW, M 1. Decedent's Name (First, Middle, Last)	oco <i>Cer</i>	tificate of L	Jeath	2. Date of Dea Month		3. Time of Dea
Physici /Medio	cal	Thelma M. Clark 4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Februar	,	4:15
Examir	ier			Bethesda			Montgome	
Foreset		Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		irthplace (State or Fo
Funeral Director		458-05-7638 1□ M 2\ F 86 Usuel Residence of Decedent	Yrs.	Months Days	Hours Min.	December	28, 1917 Te	
with the Maryland a or 28a-f ehow	2	10a. State 10b. County 10c. C	ity, Town or Lo					10d. Inside City L
9a-f	Director		North Be	10f. Zip Code			10g. Citizen of What (Country?
with t		10e. Street and Number		20852			United Sta	
s 23	a la	5550 Tuckerman Lane 11 Marital Status 12. Was Decedent Ever in 0	13 1		spanic Origin? (Spa			nericen Indian,
should be filed within 72 hours after death with the Maryland and Mental Hygiene. In Mental Hygiene hatural; or Items 23a or 28a-f ehow imarked other then "natural; or Items 23a or 28a-f ehow imartic event, the Mexical Exercit er mail be notified at	by Funeral	11. Marital Status 1 □ Never Mamed 2 □ Married 3 ☑ Widowed 4 □ Divorced 1. □ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cubai I ☐ Yes 2X No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	Rican, etc.)	Specific -	
2 hou		15. Decedent's Education	16a. Deced	dent's Usual Occupa	ation		16b. Kind of Busines	ss/industry
n "ng	Completed	(Specify only highest grade completed)	(Give	kind of work done a DO NOT use retired,	furing most of working)	ng		
with lene.	E O	Elementary/Secondary (0-12) College (1-4or 5+)	Homema	aker			Own Home	
d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 Is marked other then "natural", or traumatic event, Ing Medical Exami	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden Sumame)	
lid be lental ked	To B	Robert W. Lacy			Adele M.	Roche		
shound M	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street a	and Number or Rura	l Route Numbe	r, City or Town, State	, Zip Code)
nd 2 lith a 27 is		Paul T. Clark/ Son	17527	Black Ro	ck Road, G	ermanto	wn, Maryla	nd 20874
s 1 ar			Place of Dispo	sition (Name of natory or other place		ate	20c. Location - City	or Town, State
ant of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Donation 5 ☐ Other (Specify)			^{e)} Febru ens 7, 20	ary n4	Moorefield	I. WV
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natureny injury or other traumatic event, Ins Mexical once.		21. Signature of Funeral Service Licensus M013	22 353 Be	Name and Address	ss of Facility Robi	ert A. e. Inc.	Pumphrey F 7557 Wisc	
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he la e has	omplete			24a. Was a autop perfor	an 24b. Were prior to death			
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tranding Physician: death. stor: After this certific the funeral director,	2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Spect Natural 5 Pending investigation investigation) 28a. Date of Injury 28b. Time of Injury Work? M 28b. Time of Injury Work? M 28c. Injury at Work? M 1 Yes 2 No						
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ne Hospital 24 hours a ne Funeral	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kit of the basis of examiner: On the basis of examiner and manner stated.	nation and/or in	vestigation in my or	nining death accurr	ed at the time	tate and place and d	ue to the cause/s)
To the To the To the Complete	Me	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (It also be seen to be		29c. License	4 7578		29d. Date signed (Mo	nth, Day, Year) ey 3, 2
		30. Name and address of person who completed cause of death (Ite	em 23a) (Type,	Print)	(D)		200 40	110
	1	6 01177341141 1111	9 100	unu	10 1-11	26 1	unco	120 111

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η.			Decedent's Name (First, Middle, L.	ast)						ate of Death		3. Time of Death
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7	/Medic Examir		4a. Facility Name (If not institution, gi				4b. City, Town,	or Location o			4c. County of Dec	
			1714 Cody Drive				Silver	Sprin	ng		Montgor	nerv
	Funeral				7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		24 Hrs. 8. D. Min. (A	ate of Birth Month, Day, Yea	9. Bi	rthplace (State or Foreign country)
	Director		577-12-5671	12XM 2□ F	8	5 Yrs.	Nontris Days	110010				hington, DC
	pu ,		Usual Residence of Decedent 10a, State 10b, County		10c Ci	ity. Town or Lo	ncation					10d. Inside City Limits
	aryla shov	_	Toa. State Tob. County									1 Yes 2 No
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	with t		10e. Street and Number				10f. Zip Code			109.		ountry?
	within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28a-f show Itte Mariteal Examinat Hunt by tradified at	Funeral	1714 Cody Driv		edent Ever in U	1.0	209		-in2 (Connifu)	/aa ar Na	USA 14. Race - Am	oriest Indian
	ltem	un.	11. Marital Status 1 □ Never Married 2 □ Married	Armed Fo	rces?	J.S. 13.	Was Decedent of If Yes, specify Cul	pan, Mexican	, Puerto Rican	i, etc.)	Black, Wh	
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yland	d be ental ked c ev	To B	Charles Henry	Clark	Sr			Ka	therin	e Faira	11	
	es 1 and 2 should be fi of Health and Mental H fitem 27 is marked ot ir other traumatic ever	 	19a. Informant's Name/Relationship		<u> </u>	19b. Mailii	ng Address (Stree					Zip Code)
<u> </u>	od 2 lith a 27 is r trat		Sharon M. Voith/ Da	nohter		4328	Skymist	Terr	ace. 01	nev. MI	20832	
ള	Hear Hear term othe		20a. Method of Disposition	ug.reer_	20b.	Place of Dispo	sition (Name of	1	Date	20c.	Location - City o	r Town, State
10	y or r		1 ⊠ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec		State Ga	te of		10e) [E	ebruar 2004	-	1 0	
saltimore,	permit. Pages 1 Department of H Important: If ite sny injury or ot		21. Signature of Euneral Service Lice			_Cemet		ess of Faculit			lver Spi	ing, MD
g	Dep Impo		Buchard for	4.10		F1	Name and Addr Cancis J.	Coll:	ins Fun	eral Ho	ome Inc.	ng, MD 20901
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C			shock, or heart failure. List ont Immediate Cause (Final	one cause on e	each line.							Interval Between Onset and Death
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ê		Ju							2	4a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
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7110	Physician: The la this certificate haveral director, page 2	Be	25. Was case referred to medical examiner?	Uppoitel			0		of Death (Che	eck only one)		
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	e Hosp 124 hou e Fune letely fi	edical	(Check only 2 Medical Exa	miner: On the ba	asis of examina		h occurred at the t vestigation, in my					
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Med	one)	and man	ner stated.							
	Co. Co.	-	29b. Signature and title of certifier	1		- 1	290. Licer	se number		29a. l	Date signed (Mon	ur, Day, 1881)
,	15	ĺ	6 droed /	with	undo	n	D.	12703		Fe	ebruary	9, 2004
			30. Name and address of person who	completed caus	se of death (Ite	m 23a) (Type,	Print)				-	
			Edward J. Richa		D. 103	01 Geo	rgia Ave	#2	03, S1	lver Sp	ring, M	D 20902
	Sta	ate	31. Date filed (Month, Day, Year)	2014 32. R	legistrar's Sign		Loans	51				

			1 - For State Registrar	State of Maryland / Depa Cel	artment of Health and Natificate of Death	fental Hygie	ne 200	+ 05960		
6.	Physici	an	1. Decedent's Name (First, Middle, L.	ast)		2. Date of Death	Day Year	3. Time of Death		
	/Medi			netti		February	5 2004	8:23 P M		
	Examir	ner	4a. Facility Name (If not institution, gi		4b. City, Town, or Location of Death		4c. County of Deal			
			Suburban Hospita 5. Social Security Number 6.	AL Sex 7. Age (In yrs. last birthday)	Bethesda If Under 1 Year If Under 24 Hrs.	9 Date of Birth	Montgome			
	Funeral Director		030-32-6331 Usual Residence of Decedent	1½ M 2□ F 93 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye June 20	ar) Co	hplace (State or Foreign ountry) aly		
	/land		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits		
	Man,	to	Maryland Montge	omery Silver S	prino			1 ☐ Yes 2 🔯 No		
	in the	irec	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	ountry?		
	23a vi	ai	12905 Camellia Da	rive	20906		U.S.A.			
336	be filed within 72 hours after death with the Maryland ital hygiene. Id other than "natural", or Items 23e or 28e-1 show event. Its Medical Exercities mast be invitted at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2½☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 21X No	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W			
Maryland 21215-0036	2 hou		15. Decedent's E	Education 16a. Decex	dent's Usual Occupation	16b	. Kind of Business/	Industry		
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<u> </u>	should be nd Mental I marked o	To	Antonio Cannett			Puglisi				
<u>a</u>	d 2 st th and 7 Is n traun		19a. Informant's Name/Relationship Mrs. Erminia Car		ng Address (Street and Number or Rura					
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Baltimore,	artme ortan injur		21. Signature of Lineral Service Lice		. Name and Address of Facility Hir		ilver Sp			
ñ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es ones.		Q Duella		1800 New Hampshire					
	9		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nolications that caused the death. Do not ente			-	Approximate Interval Between		
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28/	ficate phys s the	edicai		_ d						
C. BOX	the death certificate be executed y the attending physicien and sched for use as the burial-transit	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)					
ב	hat the	۵.		contributing to death but not resulting in the un	adathing cause given in Bort I	220 Did tobacc	o vao pantsibuto ta	the cause of death?		
Hecords,	w requires that the de been signed by the should be detached	ted by		lure, Metastatic Blac				ine cause of death?		
	2 2 2	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ X	prior to co	opsy findings available ompletion of cause of		
VITAI	Physician: The this certificate hi al director, page	Be (25. Was case referred to medical examiner?		26. Place of Death			20,10		
_	2 20	2	1 ☐ Yes 2 XNo	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient		ne 5 🗆 Residence	6 ☐Other (Spec	ify)		
	ling F	Certification;	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury 28b. Time of Injury Injury	Work?	8d. Describe how in	jury occurred			
<u>s</u>	death death ctor: / the	icat	2 Accident Investigation 3 Suicide 6 Could not be	De Ole Place of laive. At home form at a	M 1 Yes 2 No	196 Lonation (24				
DIVISION	lor A after Direction by	ertif	4 Homicide determined	building, etc. (Specify)	eer, ractory, office	8f. Location (Street a City or Town, Sta		al Route Number,		
	To the Hospital or Attanding Pr within 24 hours atter death. To the Funaral Director: Alter th completely filled in by the funeral		29a. Certifier 1 X Certifying Pl	hysician: To the best of my knowledge, death	occurred at the time, date and place, a	nd due to the cause	(s) and manner as	stated		
	n 24 t	edical	(Check only 2 Medical Example)	miner: On the basis of examination and/or invi and manner stated.	estigation, in my opinion, death occurre	d at the time, date a	nd place, and due	to the cause(s)		
	To the To the Comp	Ž	29b. Signature and title of certifier	1. 10-	29c. License number	29d. D	ate signed (Month,	Day, Year)		
	ν		1.6 m. K		D29675	I	February	6, 2004		
				completed cause of death (Item 23a) (Type, F	,					
			Ralph V. Boccia 31. Date filed (Month, Day, Year)		ge Drive #4100 Bet	hesda, MD	20817			
	Sta Registra		FEB 0 9 2	32. Registrar's Signature	Sparks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 ft 6.4

			1 - For State Registrar	State of M	arytant	Ce	rtifica	ate of t	Death	id Menta		. No.	104	0596
	Physici	an	Decedent's Name (First, Middle,							Mon		Day	Year	3. Time of Death
	/Medi Examir		Marguerite Hil 4a. Fecility Name (If not institution,				4b C	tv Town or	Location of E		ruary	5, 20 4c. County	004	9:30 am
	LAGIIII	ICI	Montgomery Ger					Olney						
	Funeral			6. Sex 7. A		ast birthday)	If Uni	der 1 Year	If Under 24		of Birth		gome 9. Birthp	olace (State or Foreign ntry)
	Director		579-14-2365	1 □ M 2 🔀 F	83	Yrs.	WIGHT	Days	Tiodis		ch 7,			ington,D.C
	land ow		Usuel Residence of Decedent 10a. Slate 10b. County		10c. City	, Town or Lo	cation						1	10d. Inside City Limits
	Many -feh	ţ	Maryland Monte	omery		C + 1	an 6	Spring						1 □Yes 2 ☑ No
	with the Maryland a or 28a-f ehow be notified at	Director	10e. Street and Number	Omery		SIIV		Zip Code		·	10g	. Cilizen of V	Vhal Cour	niry?
	th wit	alD	15310 Beaverbroo	k Court. 2	- D			20906				USA		
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	5. 13.	Was De			? (Specify Yes	or No-	14. Rec	e - Americ	can Indian,
36	s afte	y F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	No			2 🙀 No		, .	,	Specify		610.
21215-0036	tural	Completed by	15. Decedent's	Year or Dates:		16a Decer	dent's LI	sual Occupa	ition		16	b. Kind of Bu	Whit	
215	nin 72 n' ni Medit	plet	(Specify only highest Elementary/Secondary (0-12)		5.1	(Give life.	kind of DO NOT	work done o	luring most of	working	10	b. Kind of Bu	isines s/ini	lustry
	giene giene er tha	Zom.	12	College (1-40)	3+)	Home	make	r				Own Ho	me	
p	be file tal Hy d oth	Be	17. Father's Name (First, Middle, La	ist)					18. Mother's	Name (First, A	Aiddle, Mai	iden Sumam	θ)	
<u></u>	ould Men Marke Marke	2	William Whippl							da Mari				
Maryland	d 2 sh h and 7 is m traum		19a. Informant's Name/Relationshi	, , , ,						r Rural Route I				
	1 and Healt		Tina C. Desrosie 20a. Method of Disposition	rs Daught	20b. Pla	ace of Disco	sition (A	iame of		ve Eld	ersbi	Location	ryla:	nd 21784
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Macinal Examiner must be notified at Once.		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Park	metery, cren Lawn	natory o Memc	r other place rial	»)					
#	satme sortar injur		21. Signature of Funeral Service Lie			22		ark and Addres	Fe s of Facility	b.9,200)4 Ro	ockvil	le,M	aryland
ä	Po E E		Fru L.	Scentro		Fr.	anci	s J.	Collin	s Funer	al Ho	ome, I	nc.	MD 20901
	\$		23a. Pert1. Enter the disease, or co shock, or heart failure. List or	omplications that caused by one cause on each li	d the death.	Do not ente	er the m	ode of dying	, such as car	diac or respira	tory arrest,	zr spr	T118 . 1	Approximate Interval Between
	Physician		Immediete Cause (Final disease or condition	_a Respin									1	Onset and Death Days
	/Medical Examiner		resulting in death)	Due to (or as									-	Jay 3
	3-13-1	-	Sequentially list conditions,	b. Metast Due to (or as	atic	Breas	t Ca	ncer					7	Years
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or injury that initiated events	340 10 (61 40										
Ć,	execting and training training and and training and training and and training and training and and and and and and and and and and	Еха	resulting in death) Last	c Due to (or as	a conseque	ence of):								
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical	•	d										
	artifica ing ph e as ti		IF FEMALE:											
Вох	eath cert attending for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal o	death 3		pregnancy				23d. Date Mon	of delive	ry Day Year
0	that the de ed by the a detached t	ysic	1 ☐ Yes 2 ♣ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time of dea	ath 5∐	Other (specify)				Widi		Day Toal
9	that the sed by detac		Part II. Other significant conditions	contributing to death b	ut not result	ting in the un	derlying	cause give	n in Part I.	23e.	Did tobaco	co use contri	bute to th	e cause of death?
Records,	quires n sign	d by									1 🗌 Yes	2 🗆 No	3 🔲 Proba	abiy 4 ⊠Unknown
000	aw requir s been si 2 should	Completed								24a.	Was an	24b. W	/ere autop	osy findings available
R	The lav	mo								-	autopsy performed	? de	ior to con	npletion of cause of
Vital	ysician: The is certificate director, pag	Bec	25. Was case referred to medical examiner?						26. Place of I	1□ \		NO I	Yes	21 X 140
of V	Physician: this certific ral director.	ို	1 Tes 2 No	Hospital: 1 ☑ Inpatie	nt 2□E	R/Outpatient	3 🗆 0	Othe	4 Nursin	g Home 5□	Residence	6 □Othe	r (Specify)
		iuo.	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Dale of Inju (Month, Da	ry Year) 2	28b. Time of Injury		28c. Injury Work	?	28d. Desc	ribe how in	njury occurre	d	
Division	tendate for:	icat	2 Accident investigat 3 Suicide 6 Could not	be on Diese of Ini	un. Al hom	o form also	M (a sta		es 2 □ No	006 1	inn (Ct.)			_
Ď	after after Direct	Certification:	4 Homicide determine	building, et	c. (Specify)	ie, iaiii, sire	et, racto	ory, orrice		City o	or Town, St	and Numbe ate)	r or Hural	Route Number,
	To the Hospital or Al within 24 hours after or To the Funeral Directompletely filled in by		29a. Certifier 1⊠ Certifying	Physician: To the best	of my know	ledge, death	occurre	d at the time	, date and pla	ace, and due to	the cause	e(s) and man	ner as sta	ated.
	the Him 24 the Figure 19	edical	one)	aminer: On the basis of and manner sta	examination	on and/or inv	estigatio	n, in my opi	nion, death o	ccurred at the t	time, date a	and place, ar	nd due to	the cause(s)
	To To com	Σ	29b. Signature and title of certifier				2	9c. License			29d. l	Date signed	(Month, E	lay, Year)
	20		Paul Bans					טמע)335		Feb.	ruary	5, 2	004
			30. Name and address of person wh					de Dec	1770 110	27 27		-		
	Sta	e_	Paul A. Bannen 31. Date filed (Month, Day, Year)	M.D. 1811 32. Registra				1		327, 01:	ney,	MD 208	532	
	Registr		FEB 0 9	2004 / 50-	Experience of	19	1	sarks	/					

State of Maryland / Department of Health and Mental Hygiene 2004 05962 For State Registra Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Α **Physician** 8 9:18 CAMINO FEB 2004 LEONARDO /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 X M 2□ F 41 Yrs. 215-67-6380 March 5,1962 Director Ecuador Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show rthan "natural", or items 23a or 28e-f sho the Medical Examinat must be notified at 1 X Yes 2 ☐ No Gaithersburg Montgomery Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 20878 Ecuador 109 Twelve Oaks Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 ∰Yes 2 □ No If Yes, Give 1984—Year or Dates: 2004 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: White Ecuadorian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Service Officer Navv 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental H 7 is marked of Renee Carlier Freile Celso Leonardo Camino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Importent: if item 27 is
any injury or other treu Maria A. Espinoza Baez Camino 109 Twelve Oaks Drive, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition t X Burial 2 ☐ Cremation 3 ☐ Removal from State February 14 Parque De Los Recuerdos Manta, Ecuador ' 4 Donation 5 Dother (Specify) 2004 Park Drive, Gaithersburg, MD 20877 21. Signature of Funeral Service (icensee 10 East Deer PAC. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disase or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown certificate has been signed by irector, page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No 1 Yes 2 🔯 No or Attending Physicien: 25. Was case referred to medical director 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛱 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After th funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1X Natural 2 Accident 1 🔲 Yes 2 No death. investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or to the Funerel Direct completely filled in by 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number GA050007 (GA) (0+1 NATIONAL NAVAL MEDICAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 USA KEVIN K, CHUNG 31. Date filed (Month, Day, Year) FEB 1 0 2004 32. Registrar's Signature State Registrar

		•	1 - For State Registrar		State	of Mary	yland	/ Depa	artmen rtificat	t of H	lealth D <i>eath</i>	and N	Mental Hy	giene Reg. No.	200	14	0596
	Physici	an	1. Decedent's Name (First, Min	ddle, Las	t)								2. Date of De Month	Day	Yea	ar	3. Time of Death
	/Media		Lewis			Char	vis				. 772	10-11	02/0	14/20			5:20 pm ^M
	Examir	er	4a. Facility Name (If not institute Washington Adv	_			1			rown, or akoma	Location	or Death			County of D Ontgon		
	Funeral		5. Social Security Number	6. S				t birthdey)	If Under	1 Year	If Unde	r 24 Hrs.	8. Date of Bi	rth			e (State or Foreign
ш	Director		244-429906	1	⅓ M 2□ F	73		Yrs.	Months	Days	Hours	Min.	(Month, D. 8/1/				Carolina
	p .		Usuei Residence of Decedent 10a. State 10b. Cou	ntv		10	nc City	Town or Lo	ocation							10d	Inside City Limits
	Aaryla Febor	ō			eorge's		•		svill	Le						1.00.	₩ Yes 2 No
	28e-	rect	10e. Street and Number					- J	10f. Zip					10g. Citiz	zen of What	Country	?
	h with	io ie	2005 Ruatan	Str	eet					2078	33			Uni	ted St	ates	3
936	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "naturel", or Itame 23a or 28e-f ehow event, the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ₺ № 3 □ Widowed 4 □ Divord		12. Was Dec Armed F 1 (**) Yes If Yes, G Year or [orces? 2 ∐ No ive	er in U.S.	. 13. Was Decedent of Hispanic Origin? (Specify Yes or North Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify:						o- 14. Race - American Indian, Black, White, etc. Specify: Black			
5-0	72 ho	eted	15. Deced (Specify only hig			}		16a. Dece (Give	dent's Usu kind of wo DO NOT u	al Occupa	ation during mo	st of work	ing	16b. Kir	nd of Busine	ss/Indus	try
121	within ne. han "	mpi	Elementary/Secondary (0-1)	2)	College ((1-4or 5+)			<i>DO NOT u</i> rman	se retired	1)			Go	vernme	ent	
d 2	Hygie Hygie ther t	e Co	8th 17. Father's Name (First, Midd	fle, Last)							18. Moth	er's Nam	e (First, Middle				
an	ld be ental ked o	To Be	Percey Cha								H	Betty	F. R:	ichar	d		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mental Pince.		19a. Informant's Name/Relation Ruby Chavis/						-				sville	-		e, Zip Co	ode)
ore,	of Head		20a. Method of Disposition 1 Burial 2 □ Crematic	n 2 🗆	Ramoval from		20b. Plac	ce of Disponence	osition (Name	me of other plac	е)		Date	20c. Lo	cation - City	or Town	, Stete
Ē	Pages ment of I ant: If its ury or o		`4 □Donation 5 □ Other			State	Ft.		colon				0/2004		entwoo		
Baltimore,	permit. Departn Imports eny inju		21. Signature of Eumeral Sept	ice Licen	\$80	2							B. Jenk Lando				ome
3760,	Physician /Medical Examiner per percentage with physicien and physicien and physicien and physicien are percentage with the principle of the physician physi	lical Examiner	d									Int	oproximate terval Between nset and Death				
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 3 Ectopic pregnancy 23d. Date of display Month Mont								delivery Da	y Year					
9	luires that n signed b	by	Part II. Other significant con- MYELO		ontributing to o		ot resulti	ing in the u	anderlying o	ause give	en in Part	l.	23e. Did tobacco use contribute to the cause of death? 1 • Yes 2 • No 3 • Probably 4 • Unknown				
Il Records,		Completed					*						24a. Was auto perf 1 Yes		24b. Were prior death	autopsy to compl ?	findings available etion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to med examiner?	lical	Hospital:		37			Oth	or:		h (Check only				
of	Phys this ral dir	10	1 ☐ Yes 2 ☒ No 27. Manner of Death		1 _	Inpatient of Injury		VOutpatie 8b. Time o	nt 3 DC	JA	4 U N	ursing Ho	ome 5 Res			pecify)	
on	ding h. After funer	tion	1 🗷 Natural 5 🗆 Per	nding estigation		of Injury oth, Day Ye	ear)	Injury	М	28c, Injun Worl 1 □]No	200. 00301100	now injury	Coccarios		
Division	or Attending after death. Director: After I in by the fune	Certification:	2 Accident investigation 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)									d Number or	Rural R	oute Number,			
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifier (Check only 2 Medi	fying Ph cal Exan	niner: On the i	e best of m basis of ex	aminatio	edge, deal n and/or ir	th occurred westigation	at the tin	ne, date a pinion, de	nd place, ath occur	and due to the red at the time,	cause(s) date and	and manner place, and o	as state	d. e cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of cer	tier	7)		11	7	29	c. Licens	e number			29d. Date	e signed (Mo	onth, Day	y, Year)
			Dand		vou	uve	K	h	\sim	D038	335			2-	-9-200	4	
R	/(4)		30. Name and address of per-	son who	completed cau												
1			DAVID CROM		M.D.	831 T Registrar's			Y BLV	/DE#3	37 SI	LVER	SPRING	,MAI	RYLAND	2	20903
	Sta Regist	ate rar	FEB 1 0			Hegistrars			(e)								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 05964 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February Day **Physician** 2252M 2004 Dorothy Thomas Canty /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner cheverly Grouge 5 riuse 405 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) July 4, 1926 6 Sax 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 5. Social Security Number **Funeral** Min Days Hours 1 ☐ M 2 💢 F South Carolina 77 250-36-9962 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show 1 XYes 2 ☐ No Funeral Director Washington D.C. 10g. Citizen of What Country? 10e. Street and Number 5357 Hayes Street, N.E. 10f. Zip Code 20019 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2XXNo Specity: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Damestic Elementary/Secondary (0-12) College (1-4or 5+) (Washington Hospital Center) 9th grade Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Againt. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if frem 27 is marked oth any injury or other traumatic event song. Bessie Brown Eliott Duncan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13900 Farnsworth Lane Unit 4307 Upper Mariboro, Maryland 20772 Judy C. Smith (Daughter) 20b. Place of Disposition (Name of cemetery, crematory ocother place Harmony Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 2/9/04 Landover, Maryland 1 Buriel 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROLLINS FUNERAL HOME, INC. 4339 HINT PL. N.E. WASHINGTON, D.C. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ck, or heart failure. List only one cause on each line mediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an 1 Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvado Sg/va7
31. Date filed (Month, Day, Year)
FEB 1 2 2004 32. Pegistrar's Signature State 2004 Registrar

			1 - For State Registrar	State of Maryland	/ Depa	rtment of H tificate of L	ealth and Death		jiene 20 eg. No.	104 05965
	Physici /Medic		Decedent's Name (First, Middle, Last) Vera	H. Car	rter			2. Date of Dea Month February	Day	Year 04 3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give s Prince George's Ho 5. Social Security Number 6. Sex 1	spital	t birthday) Yrs.	4b. City, Town, or Chever If Under 1 Year Months Days		8. Date of Birth	Year)	of Death e George's 9. Birthplace (State or Foreign Country) North Carolina
	D	_	Usual Residence of Decedent 10a. State 10b. County		Town or Loc	cation		Jan. 20	, 1939	10d. Inside City Limits
	3a or 28a-f	Funeral Director	Maryland Prince Geo 10e. Street and Number 7713 Normandy Road	orge's Pa	almer	10f. Zip Code	20785	1	0g. Citizen of W	·
36	rs after death I', or Itema 2 secultier man	by Funera	11. Marital Status 1 □ Never Married 2 【 Married 3 □ Widowed 4 □ Divorced	I2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2 XNo	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race Black	- American Indian, c, White, etc.
21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural" or Itema 23e or 28e-f ahow avent, if a Medical Exemples must be rectified at	Completed t	15. Decedent's Educine (Specify only highest grade Elementary/Secondary (0·12)	cation completed) College (1-4or 5+)	(Give I life, D	ent's Usual Occupa kind of work done d DO NOT use retired, Strative	uring most of wo	rking	16b. Kind of Bus	siness/Industry
Maryland 2	od ala be	To Be Co	17. Father's Name (First, Middle, Last) James Davis	F	201117117	Strative	18. Mother's Nar	ne (First, Middle, I Handon	Governm Maiden Sumame	
	1 and 2 sh Health and em 27 is m ther traum		19a. Informant's Name/Relationship (Ty) Calvin Larry Carter 20a. Method of Disposition	:/ Husband	7713	g Address (Street a Normandy sition (Name of	Dr. Pal	mer Park	, MD 207	
Baltimore,	t. Page rtment o rtant: If njury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Mary	land	ition (Name of atory or other place Veterans Name and Addres	Cem. 2-	18-04	Cheltenh	nam, Maryland . Home of MD,IN
Ö	Department Department	JI 18	23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death. e cause on each line.	43	08 Suitla	and Road	Suitland	d, MD 2	Approximate Interval Between
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. Massive CVA Due to (or as a consequence of): Respiratory Failure Cousto (or as a consequence of): c.							Onset and Death
Box 68760,	leath certificate be executed attending physicien and for use as the burial-transit	edicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consequent of the consequent of	y eath 3⊡	Ectopic pregnancy			23d. Date	of delivery
л О	uires that the de signed by the a d be detached	y Physician/M								
ecords,	v requ been shoul	Completed by						1 ☐ Ye	24b. W	B Probably 4 Unknown ere autopsy findings available for to completion of cause of
Vital H	Physician: The lav this certificate has ral director, page 2 :	Be	25. Was case referred to medical examiner?	nenital:		Otho		perform 1 ☐ Yes 2	ned? de £⊠No 1E	ath? ☐Yes 2☐No
ō	iing Phys h. After this funeral di	ation: To	27. Manner of Death 1 🖾 Natural 5 □ Pending 2 □ Accident investigation	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other						
DIVISION	spital or Attancours after death	al Certification;								
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical		er: On the basis of examination and manner stated.	and/or inve	estigation, in my op	number	rred at the time, da	ate and place, and od. Date signed ((Month, Day, Year)
2	5		30. Name and address 1 person who con Steven Schwartz, M			Print)	verly N	Fe Marylnad		12, 2004
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 3 2004	2. Registrar's Signature			verry, r	arymau	40/03	

State of Maryland / Department of Health and Mental Hygiene 2004 05966 1 - For State Registrar Certificate of Death Reg No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Yeer Physician 0220 AM Diers atherine 2004 ebruary Dunn /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner hestertown River Hospital Kent enter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 21 19 Birthplace (State or Foreign Country) 7. Age /In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Days 1 ☐ M 2 🛛 F 86 212-16-7962 1917 Maryland Director Usual Residence of Decedent death with the Maryland 10c City Town or Location 10d. Inside City Limits 10a. State 10b. County rithen "natural", or items 23a or 28a-f show the Medical Examinatings be notified at TYPYES 2 No MD Kent Chestertown Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 402 Morgnec Rd. Apt. 8D 21620 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 X Yes 2 □ No 1945 If Yes, Give Year or Dates: -1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3₺Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hospital Registered Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental F permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked 1 any Injury or other traumatic evegate. Sarah O'Grady Thomas Dunn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1576 Killens Pond Rd. Harrington, DE.

ce of Disposition (Name of Date 20c. Location - City or Town, State Sharon Wyatt (niece) DE. 19952 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/9/04 Old Bohemia Cem. Warwick, MD. '4 □Donation 5 □Other (Specify) Galena Funeral Home of Stephen 118 West Cross St. Galena, MD. 21. Signature of Funeral Service Licensee M00510 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · Arteriologic Sclovatic Cardio Vascular Diseaso >10 years **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the at id be detached for 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ; HTN: COPD: Hx CAUtons; Hx Breast (f); 1 Yes 2 No 3 Probably 4 Unknown been Aartic Value Calcification; Kichal Hovnis; fe Deficiency 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform Melanosis Coli; Diverticula; Hx Bilat AKA 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred funeral 27. Manner of Death After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the h 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D50996 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chestertown, MD. 21620 Neil Stoddard, MD 100 Brown St. 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 0 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 11:00 PM February 10, 2004 John Francis Doherty /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Olney Montgomery Montgomery General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 7. (Month, Day, 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax November 29, **Funeral** 1(2¥M 2□F 75 1928 New 090-22-1485 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show event, the Medical Examiner must be nutified at 1 ☐ Yes 2 A No Director Bethesda Maryland Montgomery 10g, Citizen of What Country? 10e. Street and Number 10f. Zin Code 4977 Battery Lane #302 20814 U.S.A. 'natural', or Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 239 any injury or other traumatic event, the Medical Exambles Install. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ĭ¤Yes 2□No Korean 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Conflict Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry U.S. Government Elementary/Secondary (0-12) College (1-4or 5+) Director of Publications Printing Office 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Francis Doherty Helen Turack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4977 Battery Ln., #302, Bethesda, Maryland 20814Alicia Doherty / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 2004 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen Francis Adress Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death ease, or complications that caused the death. To not enter the mode of dyld, such as cardiac or respiratory arrest, le. List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediete Cause (Final Physician 74941 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disasse or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 4 Pregnant at time of death 5 ☐ Other (specify) JYes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: Hospital: 1 Yes 2 No Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manne of Death After 1 DNatural Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation s after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L Hospital 29a. Certifier 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certified 10+1 Dooley Ē Type, Print) MOMAS AVENUE 31. Date filed (Month, Day, Year) FEB 12 32. Registrar's Signature State 2004 acks Registrar

State of Maryland / Department of Health and Mental Hygiene 2 05968 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav 1:40 a M S. Anne Delaney February 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Holy Cross Hospital Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, March 7, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F 189-26-1659 72 Director March 1931 Pennsylvania Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Maryland Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4853 Cordell Avenue #812 238 20814 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 5 Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: Specify: White 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Specialist C.I.A 12 marked other th and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be vas 1 and 2 should be variet to their and Merorent: If Item 27 is r John J. Delaney Marina Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Delaney/Brother 110 Carlisle Drive, Silver Spring, MD 20904 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, Stete permit. Pages 1
Department of H
Importent: If Ite
any injury or ott February 10 1

Burial 2

Cremation 3

Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 2004 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. Kei Skils 500 University Blvd. W., Silver Spring, M D 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer of Esophagus/Pharynx /Medical Due to (or as a consequence of): **Examiner** Neoplastic Pseudoaneurysm Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed and physicien as the burial-Due to (or as a consequence of): Box 68760, Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Year Day 4☐ Pregnant at time of death 5 Other (specify) the o detached 9 Unknown signed by ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 9 1 X Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? page certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1

☐ Inpatient Other: 1 ☐ Yes 2 🔼 No 2 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred Hospitel or Attanding 1 Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: , 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide after within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 20 and address of person who completed cause of death (Item 23a) (Type, Print) 2415 Musgrove Road, #203, Silver Spring, MD 20904 Kenneth Hauck M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 11 2004 Registrar

			State of Maryland / Depart State of Maryland / Depart Cert	rtment of Health and I dificate of Death	Mental Hygi	ene 200L	05969
			Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
	Physici		Carroll F. Davis		Month February	Day Year 7 6 2004	1:50 ^{p м}
	/Medic Examin			4b. City, Town, or Location of Deatl		4c. County of Deet	
	ZAGIIIII		Rockville Nursing Home	Rockville		Montgomer	У
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)
	Director		226-07-0099 1⊠M 2□F 91 Yrs.	7.01.110	Nov. 12,		rginia
	pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits
	sho	5					1 ☐ Yes 2 ☑ No
	28a-f	ect	Maryland Montgomery Montgomery 10e. Street and Number	V111age 10f. Zip Code	10	og. Citizen of What Co	untry?
	with	ă	19808 Bazzellton Place	20886		USA	,
	na 23	Funeral Director	11 Marital Status 12, Was Decedent Ever in U.S. 13, W	as Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	
^	r Iten	Fun	1 Never Married 2 🔀 Married 1 📆 Yes 2 □ No	Yes, specify Cuban, Mexican, Puer	o Rican, etc.)	Black, White	
3	ol', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WWII	☐ Yes 2፟█ No Specify:		Specify: Wh1	te
21215-0036	within 72 hours after death with the Maryland ene. Than "naturel", or flema 28a or 28a-f show the Medical Examinar must be motified at	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k.	ent's Usual Occupation ind of work done during most of wo.	rking	16b. Kind of Business/	Industry
N	thin	nple	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)			
N	ygier ygier rar th	S		Cleaning	n n (Circh Adiadala A	Self-Empl	oyed
yland	tal H	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, M		
7 9	i Mar Marke	10	Stuart W. Davis	Susie Address (Street and Number or Ru	C. Jacks		Zin Code)
Mar	12 sh h and 7 is n rraun		1001 1101				
a) L	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene with the masted other than "naturel", or Itema 23a or 28a-f show item 27 is marked other than "naturel", or Itema 23a or 28a-f show other traumetic event, the Medical Examinar mast two multilest at		20a Method of Disposition 20b. Place of Disposi	B Bazzellton Placition (Name of	Date 2	Omery V111	Town, State
פֿ	ages nt of : If it		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crema		uary 10		. 1
galtimore,	it. Purtue			Shington Cemetery Name and Address of Facility	2004	Adelphi,	Maryland
g	permit. Pages of Department of Histophant: If ite any injury or of once.		Fr	ancis J. Collins	Funeral	Home Inc.	no MD 20001
	40		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	O University Blv r the mode of dying, such as cardia	or respiratory arre	st,	Approximate
			Immediate Cause /Final				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Hypertensive Heart Due to (or as a consequence of):	Disease			
	Examiner		Alzheimer's Dement	ia			
М		Je.	Sequentially list conditions, if any, reaching to immediate cause. Enter Underlying				
	outed and ansit	Examiner	Cause (Disease or injury that initiated events Coronary Heart Disease or injury)	ease			
Ď	en ar	EX	resulting in death) Last Due to (or as a consequence of):				
8/60	death certificate be executed e attending physicien and of for use as the burial-transit	dlcal	d				
٥	ing pl	Med	IF FEMALE:				
X Q Q	eath certific attending p	Iclan/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of del Month	ivery Day Year
- -	y the a	hysic	1 Yes 2 No 4 Pregnant at time of death 5 Unknown 9 Unknown	Other (specify)			
7.		0	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ecords,	8 5 8	d by		,,	1 ☐ Ye	s 2 No 3 Pr	obably 4 \Unknown
Ö		ete			24a. Was ar	24h Ware at	itopsy findings available
ě	sician: The law certificate has b irector, page 2 sh	ompleted			autops	y prior to death?	completion of cause of
	n: Th ficate	e Co	25. Was case referred to medical	00 01	1 Yes 2		2 No
VII	Physician: this certific ral director,	o Be	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient	Other		nce 6 Other (Spe	ciful
ō	Phys er this eral di	-	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?	28d. Describe ho		5,7)
0	ath. r: After e funera	atlo	1 ⊠Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 Yes 2 No			
Division	al or Attending F s after death. I Director: After d in by the funera	E	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Sti City or Town	reet and Number or Ri	ural Route Number,
5	apital or ours afte neral Dir filled in	Certification:	Salar grand		2000EL1	22/2	
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) Check only 2 ☐ Medical Examiner: On the basis of examination and/or inventorial and manner stated.				
	o the o the omple	Med	29b. Signature and 4itle of certifier	29c. License number	25	9d. Date signed (Mont	h, Day, Year)
			Drowns V. Possis	D47330		February 9	2004
	12+1		30. Name and address of person who completed cause of death (Item 23.) (Type, P			LUDIGALY .	, 2007
			Thomas V. Joseph 50 W. Edmonston Dri		ille, MD	20852	
100	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sporks			
	Regist	rar	FEB 1 0 2004 Jenera 19	pparks			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** MICHAEL DANZIG I. JANUARY 25, 2004 8:47PM /Medical 4b. Cify, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner SILVER SPRING 1502 DECEMBER DRIVE #104 MONTGOMERY If Under Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days 1**X** M 2□ F 1956 212-72-9936 47 WASHINGTON, DO Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Marylend 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r items 23a or 28a-f ehow siner must be notified at 1 ☐ Yes 2 → No Director MARYT.AND MONTGOMERY SILVER SPRING 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES OF AMERICA 1502 DECEMBER DRIVE #104 20904 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. 1K Never Married 2 Married Baltimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) VOLUNTEER 6 ATC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental NAOMI LUBARSKY 7 is marked traumatic 2 SOLOMON A. DANZIG 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health an.
It if item 27 is SOLOMON A. DANZIG - FATHER 7501 DEMOCRACY BLVD. #B424、 BETHESDA MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or KING DAVID MEMORIAL GARDENS 01/30/04 FALLS CHURCH, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC 21. Signature of Funeral Service Licenses 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a MYOCARDIAL INFARCTION 3 HOURS Examinat Due to (or as a consequence of) Physician/Medical Examiner siclan and bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): the 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ARRESTED HYDROCEPHALY ģ paga 2 should be 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed performed? SEIZURE DISORDER 1 ☐ Yes 2 ☐ No 2 X No 1 Yes 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA edical Certification: To s aftar daath.

I Director: Aftar this id in by the funerel di this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 5 ☐ Pending investigation Natural 2 Accident 1 ☐ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illad in by 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. • Funeral

> 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) DROBIS, M. MD 31. Date filed (Month, Day, FEB 0 State Registrar **DHMH 16 Rev 6/95**

29b. Signature and title of certifier

29a, Certifier

(Check only one)

completaly

To the Vithin 2

12201 PLUM ORCHARD DRIVE, SILVER SPRING, MD 20904 32. Registrar's Signature

D18137

29d. Date signed (Month, Day, Year)

JANUARY 25, 2004

1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

rocks

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05971 State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 2004 1:00a M Dantzler Sr. Willie James /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 712 Lisle Drive Mitchellville 8. Date of Birth (Month, Day, Year) Jan. 1, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 → M 2 □ F **Funeral** Days 1935 245-44-2071 Charlotte, Director 69 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 1∩a State 10b. County r than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1√Yes 2□No Directo Mitchellville Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20721 United States 712 Lisle Drive filed within 72 hours after death Hygiene. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: δ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Carpet Installer Private 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental I should be marked o Rosalee Bishop Burton Dantzler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Trudy Dantzler / Spouse 712 Lisle Dr. Mitchellville, Md. 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If its any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Feb. 9,2004 Clinton, Md. Resurrection 22. Name and Address of Facility Alexander S. Pope Funeral Home 21. Signature of Funeral Service Lipcensee 5538 Marlboro Pike Forestville, Maryland 20747 M01085 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** LICI WALLS resulting in death) /Medical Due to (on as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospitel or Attending Physicien: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 | Fetal death 3 Ectopic pregnancy Month Day Year detached for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 99 4 Unknown 3 Probably 1 Tes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2□ No 1 Yes 2 No 1 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 Yes Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death unerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours and the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/0059639 applied address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Glen Jacob, M.D.

0 9 2004

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Registrar's Signature

1221 Mercantile Ln. Upper Marlboro, Md.

20774-5374

State of Maryland / Department of Health and Mental Hygiene 2004 05972 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Margaret Louise Dodd 8.33A M EBRUAIL, /Medical 1.004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 24, 1951 Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Washington, DC **Funeral** 1 M 2 4 F 215-62-6041 **Director** 52 Usual Residence of Decedent 10c. City, Town or Location 28a-f show 10d. Inside City Limits r then "natural", or Itams 23a or 28a-f shov the Medical Extrainer must be notified at Prince George's Directo Maryland 1⊠Yes 2□No Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9302 Sheridan Street 20706 U.S.A. or Itams 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: White "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) House wife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lewis В. Dodd Marjorie Lamphiear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Noel Gowen - Son 49 Valley Street, Glen Rock, PA 17327 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 04/07/2004 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery Adelphi, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Ave., Hyattsville, MD one line 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Failure PaTi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The taw requires that the death certificate be executed burial-transit Failure and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician s the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death ŏ in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ⊠Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0032761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 94 70 - Anna Polis Read. # 418 LANHAM MD. 20706 JALEH-DAEE, M.D. 31. Date filed (Month, Day, Year) FFR 0 9 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Do DD,

State of Maryland / Department of Health and Mental Hygiene 2004 05973 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Cora Augusta Simms Davis EISKUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctors Community Hospital Lanham Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1912) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 XF Months 578-24-6527 91 December 19, P.G.Co.Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28e-f show Examiner must be notified at Yes 2 No Director Maryland Prince GEorges Lanham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 9409 Van Buren Street United States 20706 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mentai Hygiene. ent: If item 27 is marked other than *naturel; or ite 1 Never Married Married ltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) D.C.General Hospital years Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Howard Simms Grace 2 19a. Informant's Name/Relationship (Type, Print)
Linwood Willis Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) 9409 Van Buren STreet:Lanham, Maryland 20706 Doris Davis Williams (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if its any injury or ot once. Feb. 12, 2004 Cheltenham, Maryland Maryland Cheltenham Veterans Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. 21. Signature of Funeral Service Licensee Janualis 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** piralory resulting in death) /Medical Due to (or as a consequence of): **Examiner** tastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖭 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MIC autopsy performed? 1 Yes 2 No certificate 1 Yes 21 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1/2 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1-QNatural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Do058275 arand Maw, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 GOOD LUCK Rd. MAHINAJ PARAND ALAVI, . Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day DOROTHY VERNETT DORSEY JANUARY | 26, /Medical 2004 12:35P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 8. Date of Birth (Month, Day, Year)
JUN. 17, 1933 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Birthplace (State or Foreign Country) 10 M XX F Months Director 579 38 3187 JUN. 70 WASHINGTON, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits or Iteme 23a or 28a-f ehov niner must be notified at XX Yes 2 □ No DC WASHINGTON Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 DELAWARE AVE. SOUTHWEST 20024 Funeral UNITED STATES death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ∑Z∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes XX No Specify: þ Specify: BLACK 3XXWidowed 4 ☐ Divorced "natural" Completed the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH DATA ENTRY CLERK event, # FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental le marked 2 HOWARD TOYER AGNES GOLDRING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a PAUL A. DORSEY / SON 12716 DENNY CT. UPPER MARLBORO, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. * 4 □Donation 5 □ Other (Specify) MT. OLIVET CEMETERY 02/03/2004 WASHINGTON, DC 21. Signature of Fundad Service Ligensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC.
4308 SUITLAND ROAD SUITLAND, MD 20746 Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Oduse (Final disease or condition resulting in death) **Physician** CARDIOPULMONARY ARREST /Medical Due to (or as a consequence of): Examiner RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit DIABETES Due to (or as a consequence of) Box 68760. Physician/Medical HYPERTENSION the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death 1 Live birth ŏ in the past 12 months?
1 ☐ Yes ※ No
9 ☐ Unknown Month Year signed by the all d be detached for 4□Pregnant at time of death Day 5 Other (specify) o. 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown VASCULAR DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed? of Vital 1 ☐ Yes XX No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes ZXXNo XXInpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred XX Natural 5 Pending investigation Injury after death. М 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide the Hospital or within 24 hours a
To the Funeral C ** Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 26 04 005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATHERINE GODFREY 1500 FOREST GLEN RD. SILVER SPRING, MD 20910 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 1 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05975 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Caroline Nkemfuruanya Dimude 02 08 7:30 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6803 Beacon Light Road Riverdale Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1□M 2 F 213-57-4623 65 Yrs Director Nigeria Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f ahow ?? is marked other than "naturel", or items 23a or 28a-f ahor treumatic event, itte Medical Examiner must be notified al 10d. Inside City Limits Maryland Prince Georges Director Riverdale 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6803 Beacon Light Road 20737 Nigeria Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other treumatic event, the Medic once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6th Housewife Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ezeonu Ezenwata 2 Ukaegboahu Nnaka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6803 Beacon Light Road Riverdale, Maryland, 20737 Calista Uzuegbu/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Family Cemetery 02-14-04 * 4 ☐ Donation 5 ☐ Other (Specify) Lagos, Nigeria 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W.H. Bacon Funeral Home, 3447 14th Street, N.W. Wash., D.C. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC PANCREATIC CANCER 3 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò 4☐Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should b 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 🛣 No 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After s after dea. 1 X Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel C Hospital 1K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 33224 FEBRUARY 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 W. Edyanston DR. Suitet M.D. 31. Date filed (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #1state of Maryland / Department of Health and Mental Hygiene Unpend Item#23a,27,28a-f,PErME, GE304/7/04eg 2004 05976

1. Decedent's Name (First, Middle, Last) Moses Drakeford 2. Date of Death 3. Time of Death **Physician** Drakeford, Jr. Masas February 05, 19:59 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 943 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Sex M 2□F **Funeral** Months 60 237-66-0578 Director 17, November North Carolina Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Itams 23a or 28a-f shor the Medical Examinar must be notified at 1 XYes 2 No Bladensburg Directo Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4245 - 58th Avenue, Apt. T-2 20710 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: **Black** ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed 2 years Truck Driver other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fund Mental I Drakeford, Sr. Moses Mary Elizabeth Wilson ည and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20710 19a. Informant's Name/Relationship (Type, Print) (Wife) permit. Pages 1 and 2 st Department of Heelth and Important: If item 27 is n eny injury or other traun 4245 - 58th Avenue, Apt. T-2; Bladensburg, Maryland Rosa Anna Green Drakeford 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 16, 2004 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. Beltsville, Maryland 21. Signature of Fyneral Service Licenses 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. 20011 pnce arranau 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease complicated by hypothermia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner death certificate be executed and that initiated events resulting in death) Last burial-t Due to (or as a consequence of) the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy ō Month Year Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 9 1 🗌 Yes 2 🗆 No 3 ☐ Probably 4 🗷 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

U⊠Yes 2□ No 24a. Was an autopsy performed? certificate 1 Yes 2□ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ₹ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□No ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: After or Attending 5 Pending investigation 1 Natural found2/5/04 found7:15p Accident 1 Yes 2 No death. exposed to cold temperatures filled in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide found outside of home 4245 58th St., Apt.T-2,Bladensburg,MD within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical å 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) verberg MD O.C.M.E. February 06, 2004 30. Name and address of paron who completed cause of eath (Item 23a) (Type, Print) Greenberg M.D 1 dShd Z 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

State Registrar 22. Registrar's Signature

1 7 2004

State of Maryland / Department of Health and Mental Hygiene 2004 05977 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ELLIOTT February 2004 6 15 A Clair /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett Oakland 6801 Gorman Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 23, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F 67 Yrs. July Pennsylvania 181-30-2806 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "natural", or items 23e or 28a-1 show any injury or other treumatic event, the Modical Examinational be notified at once. 10a. State 10b. County 1 ☐ Yes 2X No Directo 0akland MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21550 USA 6801 Gorman Road 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Korean 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: White Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Timbering 12th Logger 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Elizabeth Swarthout Elliott Bernice A1ba Clair 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diana L. Sharpless/daughter 6801 Gorman Road, Oakland, Md. 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 1 4 □ Donation 5 □ Other (Specify) Sharpless Cemetery 2/10/04 Oakland, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License Stewart Funeral Home 32 S. Second St., Oakland, Md 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Days Pneumonia /Medical Due to (or as a consequence of): Examiner Metastatic Lung Cancer Months Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examine ed by the attending physician and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 No 1 ☐ Yes 1 🗌 Yes certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3□ DOA erel Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury at Work? Certification; 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D23979 2/9/2004 H+IN A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 311 N. 4th St., Oakland, Md. 21550 Robert A. Goralski M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 11

2004

State of Maryland / Department of Health and Mental Hygiene 2004 05978 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** 10:00^{рм} 9, Thomas Wesley Emerson February 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | Montgomery 12327 Middle Road Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1(MM 2□ F 89 March 9, 1914 Virginia 226-09-8775 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a State 10b. County 10c. City. Town or Location r than "natural", or Items 23a or 28a-f show the Medical Exercit er count he notified at 1 ☐ Yes 2 ☑ No Silver Spring Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 12327 Middle Road death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No filed within 72 hours after 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced ear or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4or 5+) Security Security Guard 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be thand 2 should be fill Health and Mental H Lucy Mildred Deavers Thomas Calvin Emerson traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 12327 Middle Road, Silver Spring, MD 20906 Hazel Emerson/ Wife 20b. Ptace of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 19, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removat from State Rockville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 2004 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses Tichard 7 Mateo 500 University Blvd. W., Silver Spring, M D 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Progressive Cardiac Failure **Physician** Years /Medical Due to (or as a consequence ot): Examiner Years Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Examiner death certificate be executed and burial-trar Due to (or as a consequence ot) P.O. Box 68760, physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☑ No Cerebrovascular Accident, High Blood Pressure, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Chroni Obstructive Pulmonary Disease autopsy performed?

1 Yes 2 No page 2 certificate director, 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 X No this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death Certification: Alter Attanding 1 XNatural 5 Pending 1 Tyes 2 No ithin 24 hours after death.

4 the Funeral Director: All ompletely filled in by the fu investigation death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title ot certifier 29c. License number 0 00/0493 ala 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 809 Veirs MIll Road, #109, Rockville, MD 20851 John S. Saia M.D. 31. Date filed (Month, Day, Year) FEB 12 2004 32/Registrar's Signature State 20cks

DHMH 17 Rev 1/2001

Registrar

		1 - For State Registrar	State of Maryland	/ Depa	artmer <i>tifica</i> :	nt of Health ar te of Death	nd Menta	al Hygie Reg	ene 2 0	104	05979
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er de Items	Finara	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 Yes 2 No	13. 1	f Yes, spi	ecify Cuban, Mexican, I	Puerto Rican,	etc.)		ck, White,	
Irs aff	2		If Yes, Give Year or Dates:		1 🗌 Yes	2 No Specify:			Specif	y: WHIT	CE.
ILK ID-UUJO within 72 hours after death with the Maryland ene. than *natural; or Items 23e or 28e-f show the Madical Examiner mast be notified in	4			16a. Deced	dent's Usu	ial Occupation	of working	16	b. Kind of 8	lusiness/In	dustry
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Mal d2 st d2 st th and 7 is n traun		HANNAH BERNER/DAUC				ALIER DR.,					
Baltimore, Maryiar permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic as	И	20a. Method of Disposition	20b, Pla	ce of Dispo	sition (Na		Date		c. Location		
Saltimor sermit. Pages Department of mportant: If it	'n	1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	•			2/02/20	004 A	DELPH	T. MA	RYLAND
artme ortar injur	ei l	21. Signature of Funeral Service Licen:				nd Address of Eacility SAGEL FUN					
De la la la la la la la la la la la la la	ä	1 (Imanda 7	udeuro	10	91 R	OCKVILLE P	IKE, RO	CKVII	LE, M	ARYLA	ND 20852
	130	23a. Part1. Enter the disease, or composhock, or heart failure. List only	lications that caused he death.	Do not ent	er the mo	de of dying, such as ca	ardiac or respi	iratory arres	t,		Approximate Interval Between
Physicia	n	Immediate Cause (Final disease or condition	AMYOTROPHIC L	ATERA	L SC	LEROSIS					Onset and Death
/Medica		resulting in death)	Due to (or as a conseque	ence of):							-
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ed sit	2	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a conseque	nica orj.							
. BOX 68/6U, death certificate be executed e attending physicien and ind for use as the burial-transit	- Landa	that initiated events resulting in death) Last	C. Due to (or as a conseque	ence of):							
ate be e hysicier the buri	3		d								
58 tificati g phy as the	1										
BOX 58 leath certific	100	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan		Ectopic	pregnancy			1	ate of delive	ery Day Year
O. Co o dea he att	100	in the past 12 months?	4☐Pregnant at time of dea 9☐Unknown	ath 5□	Other (s	pecify)				or tar	54,
ords, P.O. Borneduires that the death seen signed by the atter hould be detached for u	4	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions or	ontributing to death but not result	ting in the u	nderlyinn	cause given in Part I	2:	3e. Did toba	cco use con	tribute to t	he cause of death?
ures the signer of the d		â	Antiboting to addition that have			3		1 🗆 Yes	2 🔀 No	3 Prot	pably 4 Unknown
HECOTOR he law require he has been si ge 2 should t	1						2	4a. Was an			ppsy findings available
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at be		25. Was case referred to medical				26 Place	of Death (Che		☑ No	1 🗆 Yes	2∐ No
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g Phys er this eral di				28b. Time o	_	28c. Injury at Work?			injury occu		,,
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DIVISION I or Attending after death. Director: After		27. Manner of Death 1 XNatural 2 \(\text{Accident} \) Accident investigation 3 \(\text{Suicide} \) Suicide 4 \(\text{Homicide} \) Homicide 27. Manner of Death 5 \(\text{Pending} \) Pending investigation 6 \(\text{Could not be} \) determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, sti	reet, facto	ry, office		cation (Stre ity or Town,		ber or Rura	al Route Number,
Spitel or A ours after nerel Dire											
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune			ysician: To the best of my know siner: On the basis of examination and manner stated.								
To the Hos within 24 h To the Fur completely		29b. Signature and title of certifier	and mainter stated.		2	9c. License number		29	d. Date signe	ed (Month,	Day, Year)
F ≯ F 8		1 / Ja	dy .			D0041072		משש	RUARY	2 2	004
V		30. Name and address of person who	completed cause of death (Item	23a) (Type,		D00410/Z		tro	INAUNI	49 4	004
		AZHAR M. Z. MANIP				ICUT AVE.,	KENSI	NGTON,	MARY	LAND	20895
Regi	State	a 31. Date filed (Month, Day, Year)	32. Registrar's Signatu			outs					

State of Maryland / Department of Health and Mental Hygiene 2004 05980 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** FRIEND Franklin February 7, 12 45 P M 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4881 Oakland-Sang Run Road 0akland Garrett If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Yrs. 78 March 25,1925 Maryland 220-16-5949 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Garrett Oakland MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21550 USA 4881 Oakland Sang Run Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours atter 1 ☐ Never Married 2 2 Married Maryland 21215-0036 1 ☐ Yes 2 4 No Specify: Specify: White ል 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) other than Elementary/Secondary (0-12) Construction Carpenter 7th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be f and Mental ? permit. Pages 1 and 2 should be Department of Heath and Mental Importent: If item 27 is marked any injury or other traumatic events. is marked Teets Ellen Friend Theresa Alvin Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy P. Friend/wife 4881 Oakland Sang Run Road, Oakland, Md. 21550 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Taylor Sines Cemetery: 2/10/04 Oakland, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service 32 S. Second St., Oakland, Md. 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Obstructive Lung Disease Physician Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed -transit and that initiated events resulting in death) Last Due to (or as a consequence of): burial-Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a Ö 9 Unknown <u>م</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1XYes 2□No 3□Probably 4□Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Wasan page 2 performed? Yes 2.4 No 1 ☐ Yes Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) : Atter this ce tuneral dire 1 ☐ Yes 2 No Certification; To 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 | Homicide 0 within 24 hours a

To the Funerel I

completely filled Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier, 29c. License number D27205 Umm and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 311 N. 4th St., 0akland Md 21550 Karl E. Schwalm M.D. 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State FEB 2004 Registrar

		1 → For State Registrar	State of Maryla		artment of rtificate of		Rec	2 U U L	0598
Physic	ian	1. Decedent's Name (First, Middle, La SELESTER LE)	si) ROY FERNAN	DEZ			2. Date of Death Month	Day Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, giv		<u> </u>	4b. City, Town,	or Location of De	FEBRUARY ath	5 2004 4c. County of Deet	0120
Exami	iei	MEMORIAL HOSPITAL			CUMBERL			ALLEGANY	
Funeral		Social Security Number 6. S		s. last birthday,	If Under 1 Year Months Day	r If Under 24 H	n. (Month, Day,)	(ear) 9. Birt	hplace (Stete or Foreign
Director		233-30-3002	₹ ^{™ 2□ F} 67	Yrs.			JUNE 4,1	936 WES	r Virginia
and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
Mary F sh	ţō	WV MINERAL	L	RIDGELE	Y				1 ☐ Yes 2 No
1036 ours after death with the Maryland rat', or items 23e or 28e-f show Exemirer must be notified at	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	untry?
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er des	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of If Yes, specify Cu	Hispanic Origin? Iban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White	
-0036 hours after tural, or ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:	56-'58	1 XYes 2□ N	o Specify: SF	PANTARD	Specify: WH	ITE
27275-0036 Id within 72 hours at giene natural, or the matural, or the Medical Exam	ted	15. Decedent's E	ducation		edent's Usual Occ		,	Bb. Kind of Business/	Industry
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Mar d 2 sh lith and lith and 27 is m traum	İ.	ESPERANZA WELKER			O. BOX 4		GELEY, WV	26753	.ip Code)
	1	20a. Method of Disposition	20b	. Place of Disp	osition (Name of omatory or other pi			c. Location - City or	Town, State
SAITIMOFE, Dermit. Pages 1 a Department of Hes mportant: If item iny injury or othe		1 Burial 2 ☐ Cremation 3 ☐ 3 4 ☐ Donation 5 ☐ Other (Specif			BY CEMET!	1	08/20041	FORT ASHBY	7 W.7
Saltim bermit. Pag Department mportant:		21. Signature of Funeral Service Lice		2	2. Name and Add	ress of Facility			,,,,,
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Geath certificate e attending phy of for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	etal death 3[□Ectopic pregnan □ Other <i>(specify)</i>	су		23d. Date of delification	very Day Year
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Of Vital I Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	11-2-1				eath (Check only one)		
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ding After	ation	1 Natural 5 Pending 2 Accident investigation		28b. Time o Injury	W	ury at ork? ⊒ Yes 2 ⊟ No	28d. Describe how	injury occurred	
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Detely filled	edical	29a. Certifier (Check only one) Certifying Pt 2 Medical Example	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	th occurred at the evestigation, in my	time, date and place opinion, death occ	ce, and due to the caus curred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	R		_	nse number		. Date signed (Month	11/
5/IVA) N. H. KO	of then		2	19318	•	Feb. 10.	Th 2003.
MRS		30. Name and address of person who N.A. RANJITHAN, M				CRLAND, M	ARYLAND 21.	502	
St: Regist	ate	31. Date filed (Menth, Pay Year) 00			Coals				

	1. Decedent's Name (First,				Gertificate of		2.	Date of Deat	th Day	Year	3. Time of Death	
Physician /Medical	Melvin Arth	nur Freei	man, Sr.						29, 20	004	1:30 p.	
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ral [104 Freeman					21620			USA		and the state of	
r Items 23	11. Marital Status		2. Was Decedent Armed Forces?	?	13. Was Decedent If Yes, specify (of Hispanic (Cuban, Mexic	Origin? (Specify can, Puerto Rica	Yes or No- in, etc.)		ck, White,	can Indian, etc.	
by F	1 ☐ Never Married 2[3 ☑ Widowed 4 ☐ Dr		1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:	NO	1□ Yes 2□	No Speci	ty:		Specify	Blac	·k	
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	DAP		1 - For Unpend Item #23a Registrar	State of Ma pt.II,27 pe	aryland/De r me G828	partment 126104 t ertificate	of Heal	lth and N ath	lental Hy	ygiene /	2004	05983			
	. Obviolati		1. Decedent's Name (First, Middle, Last	1)					2. Date of D	eath Day	Year	3. Time of Death			
	Physici /Medio		Joe		Ford				FEBRUA	ARY 6,2	2004	7:55p M			
	Examir	ier	4a. Facility Name (If not institution, give 15601 ST. PHILLIE	PS DRIVE		AQU.	ASCO	ation of Death		PRIN	unty of Death	ORGE's			
	Funeral Director		219-30-2033	X 7. Age M 2□F	o (In yrs. last birthd 51 Yrs	Months		Jnder 24 Hrs. ours Min.	8. Date of B (Month, D June	10,1952	9. Birth Cou Mary	place (State or Foreign Intry) Land			
	land ow		Usuat Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location	<u>-</u>					10d. Inside City Limits			
	Mary F-f ah	tor	Maryland Prince Ge	eorges	Aquaso	co						XXYes 2 ☐ No			
	or 28	Jirec	10e. Street and Number			10f. Zip	Code			10g. Citizer	of What Cou	intry?			
	ath w	rai	15601 St. Phillips			206				USA					
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other treumatic event, the Medical Examinat must be notified at ances.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	Ever in U.S.	3. Was Deceded If Yes, special Yes 2		nic Origin? (Spi exican, Puerto ecity:	ecify Yes or N Rican, etc.)		Race - Ameri Black, White ecity: Bla	, etc.			
5-0	72 hc	eted	15. Decedent's Edi (Specify only highest grad		16a. De	cedent's Usual	l Occupation k done during	most of work	in <i>g</i>	16b. Kind	of Business/Ir	ndustry			
21215-0036	s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than other treumatic event, the Me	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Skilled Labor 18. Mother's Name (First, Middle, Last)								Agriculture					
and	be fill ad off	17. Father's Name (First, Middle, Last) 18. Mother's Name 19. Dohn 17. Father's Name (First, Middle, Last) 18. Mother's Name Mary							First, Middle: [Estel]		^{mam⊕)} Hawkir	20			
Maryland	hould id Mer mark matic	John Henry Ford Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura													
S	od 2 s lith an 27 is r treu	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rules) 19c. Mary Estelle Ford/Mother 15601 St.Phillips Road A								-					
Baltimore,	permit. Pages 1 an Department of Hea Importent: if Item eny injury or othe once.		20a. Method of Disposition ↑ Burial 2 □ Cremation 3 □ 1 ↑ 4 □ Donation 5 □ Other (Specify,	Removal from State	20b. Place of Di	sposition (Nam	e of	, ,	Date	20c. Locat	ion - City or T	own, Stete			
altir	partme		21. Signature of Funeral Service Licensee 22. Name and Address of Facility												
ä	Depared Impo		Odessa Off	/1	MO1323	Adams F	uneral	. Home 1	P.A. Ac	quasco,	Maryla	and			
	Physician /Medical Examiner	J.	23a. Part1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Atheroso Due to (or as	the death. Do not the clerotic Ca a consequence of):				or respiratory a	arrest,		Approximate Interval Between Onset and Death			
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6876	ficate be physici s the bu	edic		d											
.O. Box	that the death certifics ed by the attending pt detached for use as t	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pre 5 □ Other <i>(spe</i>				23d	. Date of deliv Month	ery Day Year			
Д.	es that igned b be deta	by Pł	Part II. Other significant conditions co	entributing to death be	ut not resulting in th	e underlying ca	iuse given in l	Part I.	23e. Did	tobacco use	contribute to t	he cause of death?			
rds	w require been sig should b	ed b	Chronic Ethanolism						1 🗆	Yes 2□N	o 3 Pro	bably 4 Munknown			
Records,	e las has je 2	Completed									prior to co death?	opsy findings available impletion of cause of			
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Division	ding h. After fune	Certification:	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office							how injury of					
Divi	in Die f		4 Homicide determined	building, etc	:. (Specify)				City or To	iwn, State)		al Route Number,			
	To the Hospitel within 24 hours a To the Funerel I completely filled	ledical	(Check only 2 Medical Exam one)	rsician: To the best of iner: On the basis of and manner sta	examination and/o	investigation,	in my opinion	n, death occurr	and due to the ed at the time.	date and pla	ce, and due t	o the cause(s)			
) r	To the within To the comple	Σ	29b. Signature and title of certifier				CME	nber]	29d. Date si FEBRUAI	gned (Month, RY 7,2	Day, Year) 2004			
	DB			10,MP		11		Stree	t, Bal	timore	, Mary	land 21201			
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 3	2004 32. Registra	ar's Signature	Sparte									

DHMH 17 Rev 1/2001

		4	For State Registrar	State of Ma	aryland	Depa / D <i>Cei</i>	artment of h tificate of i	lealth and N Death		giene Reg. No.	2004	05984		
		_	1. Decedent's Name (First, Middle, Las	t)					2. Date of Dea Month	ath Day	Year	3. Time of Death		
	Physicia		Phyllis Burleson	Fish					Februar	-	2004	3:00 P ^M		
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of Death			County of Death			
			25 Elder Place				Indian	Head			C.	harles		
	Funeral		5. Social Security Number 6. Se			ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 1	h V. Year)	9. Birth	place (State or Foreign intry)		
	Director		003-09-0072	□M 2GF	8	3 Yrs.			July 1	7, 1	920 V	ermont		
	and W	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits		
	Maryli I sho	ō	Maryland Charle	C	Tnd	ian He	had.					1 ☐ Yes 2 ☐No		
	28a-	ect	10e. Street and Number	<u></u>	LIII	Tall He	10f. Zip Code			10g. Citi	zen of What Cou	intry?		
	with Sa or	Funeral Director	25 Elder Place				2	0640		U	.s.A.			
	ms 2%	era	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		14. Race - Ameri Black, White			
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, the Modical Examinat must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		1 Tes, specify Cubs 1 □ Yes 2 Q No	Specify:	ricali, etc.)			hite		
0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece	dent's Usual Occup	ation during most of work	king	16b. Kii	nd of Business/Ir	ndustry		
21	within 7 ene. than "r	ם	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	3)						
7	filed wi Hygien other th	S	12			Seci	retary	18. Mother's Nam	a /First Middle		S. Gove:	rnment		
n a	2 should be filed withir and Mental Hygiene. Is markad other than aumatic event, Its M.	Be	17. Father's Name (First, Middle, Last) Frank W. Shepard											
3	J Men J Men narka natic	٦	19a. Informant's Name/Relationship (7	Gene Print)		10h Mailir	on Address (Street		Blanche Rowell Rural Route Number, City or Town, State, Zip Code)					
Maryland	d 2 sl th an 17 is r traur		Phyllise Wise / d	•			•	s Place;		-				
6	of Health of Health litem 27 i		20a. Method of Disposition		20b. Pl	lace of Dispo	sition (Name of natory or other place		Date	20c. Lo	cation - City or T	own, State		
altimore,	ages ant of it: If il		1 ⊠Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	ry February	ary 13,	l, Maryland								
Ħ	permit. Pages Department of Important: If i any injury or one		21. Signature of Funeral Service Licen		ss of Facility Wi	lliams	Fune	e. P.A.						
ä	Departiment Department		Musla mill	um	M006	68 4	270 Hawt	horne Roa	d; Indi	an H		ryland 20640		
			23a. Part1. Enter the disease, or comp	olications that cause one cause on each li	the death	. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between		
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Immediate Cause (Final disease or condition											
4	/Medical		resulting in death)	Due to (or as										
	Examiner		Sequentially list conditions,	b. Due to (or as		ionae afti				-				
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	derice or).								
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68760,	ficate be execu physician and s the burial-tra	ä		d										
687	± 00 m	edicai												
Вох	death certi e attending d for use a	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna		Ectopic pregnancy	,		1	23d. Date of delivers			
	o o	Physician/M	in the past 12 months? 1 Yes 2 No	4☐Pregnant a 9☐ Unknown			Other (specify)	·			MOHIT	Day Year		
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3ec	has ge 2 s	mpi							autop perfo	rmed?	prior to co	ompletion of cause of		
a			25. Was case referred to medical			_		26. Place of Dea	1 ☐ Yes	2. No	1 ☐ Yes	2 L No		
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of	Attending Physician: r death. ector: After this certific	n; To	27. Manner of Death	28a. Date of Inju		28b. Time o			28d. Describe					
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Division of Vital Records,	r Attend er death rector: /	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of In building, e	jury - At ho tc. (Specify	ome, farm, st	reet, factory, office		28f. Location (S City or Tox			ral Route Number,		
	ital o irs aft ral Di ted in													
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	Medical	29a. Certifier t⊠ Certifying Pt (Check only 2 Medicel Examone)	ysician: To the best miner: On the basis of and manner s	of examina	wledge, deat tion and/or in	h occurred at the tile vestigation, in my o	me, date and place opinion, death occu	rred at the time,	date and	place, and due	to the cause(s)		
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1.tts	MIL	7	29c. Licens	203	/	29d. Daj	e signed (Month	, Day, Year)		
,			> mus 0	- Just	1			0 2101	*		11101			
(t85		30. Name and address of person who	L GATHG	RNO	000 ,	10. 120	0 470 C	KO AL	YR (CRHTTER	WANDORF		
	Sta Regist	State 31. Date filed (Month: Pau Byear) 3 2004 32. Refistrar's Signature,												

State of Maryland / Department of Health and Mental Hygiene 2004 05985 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 30, 2004 2:40p. Roberta Agnes Ford /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kent Chester River Manor Chestertown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 10/15/1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1 M 2 3 Virginia Yrs 85 Director 222-30-2581 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Sudlersville Maryland Oueen Anne's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 21668 1001 Roe Road USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 【No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own home 12 Home maker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othn any injury or other traumatic avent, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Berthe L. Kiser Hiram B. Tiller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 621 Millington Road, Sudlersville, MD PEnny George/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Chesapeake Cremation Center 2/2/2004 Stevensville, Maryland 21. Signature of Funeral Service Licensee Fellows, Helienbein & Newnern Funeral Home, PA 370 W. Cypress Street, Millington, Maryland 21651 mentellas Approximate Interval Between Onset and Death Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NOW GESTIVE HEART **Physician** URars /Medical Examiner REGURGITAMON EVERE MITRAL year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month for Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown detached the 9 Unknown δ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. B 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? has funeral director, page 2 autopsy performed certificate 2 No 1 Tyes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) No No Hospital: Other: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 1 Tes After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital **SCentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Fune completely fi (Check only the 29b. Signature and title of certifier HILTHER D0041587 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A. Noble, 122 Speer Road, Chestertown, Maryland 21620 31. Date filed (Month, Day, Year) 32. Register's Signature State Registrar

				State of Maryland / Dep 1 - State Registrar Ce	artment of Health and M rtificate of Death		ene . No. 2004	05986
		Dhysisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month FEBRUARY	Day Year	3. Time of Death
	1	Physicia /Medic		LEWIS BURDETTE FRENCH	4b. City, Town, or Location of Death	FEBRUARY	6 2004 4c. County of Deal	2:57 P M
	1	Examin	er	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL	SILVER SPRING		MONTGOM	
	3	Funeral Director		5. Social Security Number 116 09 3144 6. Sex 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		8. Date of Birth (Month, Day,) Sept. 9	(ear) 9. Bird (1918 Ne	hplace (State or Foreign buntry) W York
		pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or U	ocation			10d. Inside City Limits
		death with the Maryland ims 23e or 28a-f show ir nest be notified at	for		tt Park			1 SYes 2 □ No
		or 28a	lrec	10e. Street and Number	10f. Zip Code		g. Citizen of What Co	
		ath wi	ral	10804 Keswick Street	20896		United St	
	36	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or Itams 23e or 28e-f show then traumatic evant, the Medical Examinar must be inclified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Ammed Forces? 1 ☑ Yes 2 □ No If Yes, Give WWII Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	Black, Whit	
	2-00	72 hou natura lical E	eted I	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of work		6b. Kind of Business	Industry
0	2121	e filed within 7 al Hygiene. I other than "r vant, the Med	Be Completed	life.	DO NOT use retired) Imber		P1 umbin	g
French	Maryland 21215-0036	d be filed intal Hyg ed othe c evant,	Be C	17. Father's Name (First, Middle, Last) Harold David French	18. Mother's Name	e (First, Middle, Mi Catheri		S
江	aryl	12 should be f and Mental b is marked of raumatic evan	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Run			
D	e, N	1 and 2 Health em 27		20b. Place of Disposition	04 Keswick Street,		Dc. Location - City or	
ewis	Baltimore,	Pages nent of I	. 3	1 ⊠ Burial 2 □ Cremation 3 □ Removal from State • 4 □ Donation 5 □ Other (Specify) Flower I			Gaithersbu	rg, Md.
<u>P</u>	Balti	permit. Pages. Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licensee **Burief** H- Barcher**	22. Name and Address <i>of</i> Facility Muriel H. Barber P. O. Box 5038,	Funeral Laytonsy	Home	20882
				23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. SEPTIC S Due to (or as a consequence of):				
		Examiner	<u>.</u>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	HORAX			
		cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c				
	8760,	sician and burial-transit		resulting in death) Last Due to (or as a consequence of):				
	687	tificate ng phys as the	ledic	u				
	P.O. Box 68	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
		quires that I n signed by uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			o the cause of death? robably 4 Minknown
	Division of Vital Records,	The law require ate has been si page 2 should t	Completed			24a. Was an autopsy perform 1 🗆 Yes 2	ed? prior to death?	utopsy findings available completion of cause of
	Vita	ysician: The is certificate hidirector, page	Be	25. Was case referred to medical examiner?	Other	th Check onl one		
	n of	ding Phys h. After this funeral di	on: To	1 ☐ Yes 2 ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐	of 28c. Injury at Work?	28d. Describe how	nce 6 ⊡Other (Spe w injury occurred	icity)
	ivisio	To the Hospital or Attandii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
		To the Hospital or Attanwithin 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, investigation, in my opinion, death occur	, and due to the ca rred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
		o the	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mon	th, Day, Year)
	•	6+1°		Y celly happen or us	000525	55	February 8	3, 2004
		v • ·		30. Name and address of person who completed sause of death (Item 23a) (Type Gabby Fossett, M.D. 1500 Forest (e.Print) Glen Road, Silver S	Spring, M	d. 20910	
		St Regist	ate trar	31. Date filed (Month, Day, Year) FEB 11 2004 32. Registrar's Signature	Sporks			

Nelly	R. Fu	ıer	ites	Pleas	se Type or	Print i	n Black	Ind	elible Ink.	Ensu	re All	Copies	Are L	.egible).	
04-0067 UNK 04-	-	-	For State Registrar		State o	f Mary	land / D	epai	tment of F	lealth a	ınd Me	ental Hy	giene Reg. No.	200		0598
DAP	Physicia		1. Decedent's Name Ne11y	(First, Middle		s						2. Date of De Month	Day	2004	ar	Time of Death
T.	/Medica Examine		4a. Facility Name (## UNIVERSIT	not institution	give street and nu				4b. City, Town, o BALTIMO		f Death	THIOTHIC		county of D		100
	Funeral Director		5. Social Security Nu 579-08-93 Usual Residence of D	328	6. Sex 1 □ M 2X F	7. Age (In 24	yrs. last birth Y	rs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Bir (Month, Da Dec 5,	iv. Year)		Country)	(State or Foreigi Lvador
Maryland	a-f ehow		10a. State	10b. County	George's		Clinto		ation							nside City Limits
th with the	23a or 28s	ai Director	10e. Street and Num 10905 Per		2				10f. Zip Code 20735			1	Unite		tes	
036 urs after dea	al', or items	by Funerai	11. Marital Status 1 Never Marrie 3 Widowed 4	d 2⊠ Marn	12. Was Dec Armed F	orces? 2≽(⊡xNo ive	in U.S.	lf '	as Decedent of H Yes, specify Cuba XYes 2 □ No	an, Mexican Specify	gin? (Spec , Puerto R Hispa	ican, etc.)		Specify:	merican Ir hite, etc. panis	
1215-00	ne. han "natura a Medical E	Completed	(Specif		t grade completed)	1-4or 5+)	(Give ki life. Di	nt's Usual Occup nd of work done O NOT use retired	ation during most d)				d of Busine	ss/Industr	
and 2	ental Hygie ced other t	To Be Co	17. Father's Name (F	_	Last) Cordova		DTT	TT11	g Manage			(First, Middle		ivate Gumame)		
altimore, Maryland 21215-0036	Department of Health and Mental Hygiene. Important: If Item 27s or 28s-f show important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, Its Medical Evantiner must be invitited at once.		19a. Informant's Nar Victor A 20a. Method of Dispo 1 Burial 2 □	Y Fuer	nip <i>(Type, Print)</i> ntes/ Hus 3	State 2	10 Ob. Place of I	905 Disposi	Penny A	and Number	r or Rural inton Da	Route Numb MI) 2(er, City or 1735 20c. Loc	ation - City	or Town,	State
Baltim Permit. Pa	Departmen Important: any injury once.		4 □Donation			en		22. A	t Cemete Name and Addre lexander 517 Penn	S of Facility	ope F	uneral	L Home		on DC	
	ıysician Medical		23a. Part1. Enter the shock, or head Immediate Cause (Fidisease or condition resulting in death)	failure. List Final	a.	each line.	death. Do no	et enter	the mode of dyir	ng, such as	cardiac or	respiratory a	rrest,	υ−−∠∀	App Inte	proximate rval Between set and Death
nted C	xaminer	miner	Sequentially list con if any, leading to important cause. Enter Under Cause (Disease or that initiated events	iying 🚽	b	(or as a co	nsequence of	f):								
), exec	ial-tr	Exa	resulting in death) L.	ast	Due to	(or as a co	nsequence of	f):								
Records, P.O. Box 68760,	/ the attending ; ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?		birth 2 nant at time	Fetal death		ctopic pregnancy Other (specify)	У			23	3d. Date of Month	delivery Day	Year
rds, P.O.	been signed by the should be detached	рy	Part II. Other signific	cant condition	ens contributing to	death but no	ot resulting in	the und	lerlying cause giv	en in Part I.			obacco us Yes 2	,		use of death?
/ital Records,	page 2 shou	Completed										24a. Was auto perfo 1 Yes		24b. Were prior death	autopsy to comple	indings available tion of cause of No
/ital	ertificate actor, pag	Be (25. Was case referre	ed to medical	Hospital:				0#		of Death	(Check only	one)			

To the Hospitel or Attending Physician: The within 24 hours after death.

To the Funeral Diractor: After this certificate completely filled in by the funeral director, par Division of Vital

25. Was case referred to medical examiner? 1X Yes 2 □ No 27. Manner of Death 1 | Natural 5 Pending investigation 2 Accident

3 🗍 Suicide

4 - Homicide

Hospital: 1 | Inpatient 2 | XER/Outpatient 3 | DOA

28a. Date of Injury (Month, Day Year) -24-04 6 Could not be determined

28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 6:30 AM

OCME

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 🛮 No

OCCUPANT IN VEHICLE, EJECTED 28f. Location (Street and Number or Rural Route Number, City or Town, State) SIS I 295 ART 195 DIMEDUMERCOM

JANUARY 25,2004

29a. Certifier (Check only one) 29b. Signature and title of certifier

City or Town, State)

SSI 25 of RT 105 MeS Must

Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

23Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Certification:

Medical

MAYAMM Date filed (Month, Day, Year)
FEB 0 9 2004 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 05988 Certificate of Death 3. Time of Death 2. Date of Death dent's Name (First, Middle, Last) 3:00 AM **Physician** ROOTY 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Hospital Center Cheverly Prince George's 8. Date of Birth (Month, Day, Oct 2, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Hours Months Days 1⊠M 2□F 1953 578-72-5255 50 Washington DC Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ral, or itama 23a or 28a-f shov Examiner must be nutified at 1X Yes 2 □ No Director Ohio Montgomery Dayton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 604 Willow Spriggs Drive 45427 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 es. Give 1 ☐ Yes 2 ☑ No Specify: Specify: 3X Widowed 4 ☐ Divorced Year or Dates: Black "natural", er than "nature". If a Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) ould be filed withi Mental Hygiene. Police Officer permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other til any injury or other traumatic event, ILLA ODGE. Government is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eugene Waldon Flemister Naomi Rhodes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Naomi Rhodes (mother) 5407 Hoover Avenue #236, Dayton OH 45427 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Dayton, Ohio VA Cemetery 2/13/2004 ⁴ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home Tino 9013 Annapolis Road, Lanham, MD 20706 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or cometications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** FAILLIZE Cuil Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner MRY FAILURE The law requires that the death certificate be executed ACUTO and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Po Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed 2□ No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? filled in by the funeral director Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Puneral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 24 To the F the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tsion Berhane, M.D. 3001 Hospital Drive, Cheverly, MD 20785 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 0 9 2004 Registrar

	1	For State Registrar	State of Maryla	ind / Depa	artment of F rtificate of	lealth and Me Death	ental Hygier Reg. N	2004	05989
ೆ Physicia /Medica Examine	n al	Decedent's Name (First, Middle, La. CLYDIE P. FREEMA Facility Name (If not institution, giv.)	N				2. Date of Death Month C FEBRUARY	02 Year 02 2 004	3. Time of Death 6:25P M
uneral rector		358 28 6450		s. last birthday)	FORES If Under 1 Year Months Days	Hours Min.	3. Date of Birth (Month, Day, Yea (AN . 20,	PRINCE GEO 9. Birthplac Country 1934 MISSIS	e (State or Foreign
23a or 28a-f show ust be notified at	Director	Usual Residence of Decedent		City, Town or Lo	LLE				. Inside City Limits XXX Yes 2 ☐ No
	by Funeral Dire	10e. Street and Number 8001 BOUNDARY DRT 11. Marital Status 1 Never Married 2 Married 3 Widowed 4XX0 ivorced	VE 12. Was Decedent Ever in Armed Forces? 1 □ Yes XX No If Yes, Give Year or Dates:		10f. Zip Code 20747 Was Decedent of H f Yes, specify Cubin	lispanic Origin? (Spec an, Mexican, Puerto R <i>Specify</i> :	UNI	TED STATES 14. Race - American Black, White, etc Specify: BLAC	Indian,
than "netura the Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working d)	7	Kind of Business/Indus	stry
evant,	Be	17. Father's Name (First, Middle, Last) ALPHONSO GASAWAY				18. Mother's Name (First, Middle, Maide SEMAN	en Sumame)	
If itam 27 Is or other trau		19a. Informant's Name/Relationship (LINDA WILKINSON / 20a. Method of Disposition XXBurial 2 Cremation 3	DAUGHTER 20b Removal from State	12006 Place of Dispondemetery, crem	ISHTAR sition (Name of natory or other place	ST. FT. W	ASHINGTON te 20c.	y or Town, State, Zip Co N MD 20744 Location - City or Town	, State
Important: any injury o		* 4 □Donation 5 □Other (Specification of Fundamental Service Licer		MA	. Name and Addre	FUNERAL H	OME OF MA	ARYLAND, M ARYLAND, INC ND, MD 2074	
an and rial-transit	Ical Examiner	23a. Part1. Enter the disease, or com shock, for heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or in fur) that initiated events resulting in death) Last	a. H: TAS IAT IC I Due to (or as a conse	LIVG CANCE equence of):	2001	ig, such as cardiac of	espiratory arrest,	In	oproximate terval Batween nset and Death
attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 donths? 1 □ Yes 2 ₩ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy	/		23d. Date of delivery Month Da	y Year
eugi p eq	2	Part II. Other significant conditions o	contributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.		o use contribute to the o	
ate has	Completed						24a. Was an autopsy performed?	death?	findings available etion of cause of
After this funeral di	6B 0	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No 27. Manner of Death X Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	4 Nursing Bonn		6 □Other (Specify) jury occurred	
8 6	Certification:	3 Suicide 6 Could not be determined	building, etc. (Spec	cify)			City or Town, Sta		
e Fune	edical	one) 2 Medical Exam	ysician: To the best of my kininer: On the basis of examinand manner stated.	nowledge, death nation and/or inv	estigation, in my o	pinion, death occurred	d due to the cause(at the time, date a	(s) and manner as state nd place, and due to the	d. e cause(s)
	Σ	29b. Signature and title of certifier	10		29c. Licens		29d. D	Date signed (Month, Day	v, Year)
To the		30. Name and address of person who	nel			37529	~	15/04	

		1 - For State Registrar	State of Ma	arylan		artment rtificate			ınd M		jiene _{leg. No.} 2	11111.	05990
Physic /Medi	cal	1. Decedent's Name (First, Middle	Jame	5	Gr	- iff	7h	Location o	f Death	2. Date of Dea Month	Day 7	Year 04 county of Death	3. Time of Death
Examii Funeral Director	ner	4a. Facility Name (If not institution, garrett County M 5. Social Security Number 210–12–9077	emorial Hos	p ita (In yrs.) 33	ast birthday) Yrs.	Oak If Under	land		24 Hrs.	8. Date of Birth (Month, Day July 14	y Year)	Garret 9. Birth Con	
v	or	Usual Residence of Decedent 10a. State 10b. County MD Garr	ett		, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
laryland 21215-UU36 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinar must be invitible at	Funeral Director	10e. Street and Number 3991 Friendsvill	e-Addison R	oad		10f. Zip	1531		2 (5		U	en of What Cou	
5-UU30 72 hours after de natural', or items dical Examinar m	b	11. Marital Status 1 □ Never Married 2 □ XMarried 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 12 Yes 2 1 1 Yes, Give Year or Dates:	No		was Deced if Yes, spec		Specify:	, Puerto f	cify Yes or No- Rican, etc.)	5	Black, White	hite
Z1Z15-U 3d within 72 h rgiene. er then "natu i, the Wedsel	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12 th	Education grade completed) College (1-4or 5	i+)	16a. Dece (Give life. Trans	dent's Usua kind of wor DO NOT us MISSI	k done d e retired)	uring most)		ng		of Business/li Transm	issions Corp
aryland 2 should be filed and Mental Hygi s marked other sumatic event, 1	To Be C	17. Father's Name (First, Middle, La Ernest Grover Gr 19a. Informant's Name/Relationshi	iffith		10h Mailie	ng Address	/Street a	Mary	wil	(First, Middle, .ma Wass I Route Numbe	3		in Code)
7 2 mg 5		Mabel R. Griffit	h/wife	20b. P		Frie	ndsv	ille-	-Addi	son Rd.	20c. Loca	iendsvi	ille,MD 2153 Town, State
Baltimore, permit. Pages 1 a Department of Her Importent: If item any injury or othe		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Service Line) 21. Signature of Funeral Service Line	cify)	Add	N	2. Name and lewman	d Addres Fun	s of Facility	y Home	2004 es, P.A.	, PC		75
18760, crate be executed Example with physician and physician and street sthe burial-transit	Ical Examiner	shock, or heart failule. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cerel Due to (or as b. Hupe	a conseq a conseq	uence of): (C) uence of):	n	ar	ac	Co	Pent,	150	hemo	Interval Between Onset and Death
Geath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3	⊒Ectopic pr ⊒ Other <i>(sp</i>					23	3d. Date of deliment	very Day Year
0 8 5 g	þ	Part II. Other significant condition	s contributing to death b	ut not res	ulting in the u	inderlying c	ause give	en in Part I.					the cause of death?
The the page	Completed											death?	topsy findings available ompletion of cause of
on of Vital F ding Physicien: Th h. After this certificate funeral director, pag	ilon: To Be	25. Was case referred to medical examiner? 1						26. Place of Death (Check only ident 3 DOA Other: 4 Nursing Home 5 Res of 28c. Injury at Work?					ify)
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DIVI. To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	(Check only 2 Medical E	Physician: To the best xaminer: On the basis o and manner st	f examina		vestigation		oinion, dea		ed at the time, o	date and p		to the cause(s)
To To corr	2	29b. Signature and title of earthfer.	who	death (Iter	n 23a) (Type,	1		2 4	60	_	2/	7/0	. Jay, 1081)
S Regis	tate	Sotiere Savopoul 31. Date filed (Month, Day, Year)	Los, M.D., 2	208 M	arylar		, Su	ite 3	3, Mt	. Lake	Park	, MD 2	1550

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month FEBRUARY **Physician** 9, 2004 2:30 EDWIN BEATTY GAITHER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GARRETT DENNETT ROAD MANOR NURSING HOME OAKLAND If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year, JAN 8, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**©** M 2□ F WV 233-44-5380 74 Director Usual Residence of Decedent with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event. If a Medical Examinar must be notified at 1 Yes 2 No Director WV GRANT BAYARD 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 26707 USA SPRUCE STREET death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. and I is marked other than "natural", or its 1 Never Married 2 Married 1 ☐ Yes 2 🕏 No Baltimore, Maryland 21215-0036 Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TECHNICIAN UTILITY COMPANY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MILLER GATTHER PAULINE EDWIN Α. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) P.O. BOX 148 BAYARD, WV 26707 EDITH GAITHER - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or ance. 2/11/04 BAYARD, WV BAYARD CEMETERY *4 □ Donation 5 □ Other (Specify) 21. Signatury of Juneral Servi 22. Name and Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 dole 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Examiner atheroscherous sides that the conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) by the a 1 ☐ Yes 2 ☐ No 9 Unknown signed by d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performed? 2 🔽 2 🗌 No no Thy soid 1 Tes 25. Was lase referred to hedical examiner? To the Hospitel or Attanding Physicien: 26. Place of Death (Check only one, Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: ဥ 1 ☐ Yes 2 No 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funaral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending 2 🗆 No 1 🗌 Yes investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26650 erson who completed cause of death (Item 23a) (Type, Print) 13079 mal 31. Date iled (Month 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05992 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 9:00a MARGARET WALLACE GODWIN February 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Mar 7 192 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 2 F 78 217-20-3645 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rai', or itams 23a or 28e-f show Examiner investible incilling at 1 XYes 2 No Kent Dover Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 39 Mitscher Rd. 19901 U.S.A. Funera 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Infortent: If Item 27 is marked other than "natural", or Itan important: If Item 27 is marked other than "natural" or Itan appriatury or other traumatic event, the Medical Evanirations. 9008. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Plastics Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Inspector Manufacturer 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Wallace Bertha Dixon ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (daughter) 9301 Edgewood Dr. Gaithersburg, MD. 20877 Dale Huffman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Crumpton Cemetery 2/6/04 Crumpton, MD. * 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Galena Funeral Home of Stephen 118 West Cross St. Galena, MD. L Schaech 21635 M00510 1_Inter the crease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hand failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cau (Final disease or condition resulting in death) **Physician** months Metastatic Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physicien for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 4 Pregnant at time of death the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2X No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 Yes 2X No Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 DOther (Specify) OSDICE 1 ☐ Yes 2X No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funerel Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signa 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison 6001 Muncaster Mill Rd. Rockville, MD. 20855 31. Date filed (Month, Day, Year) 32. Registr State 0 4 2004 Registrar

Faye Denise Green 04-01109

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	RJ		State of Maryland / Department of State of Maryland / Department / Depart	of Health and Mental H of Death	Hygiene 2004 05993						
1	Physici /Medio	cal	Decedent's Name (First, Middle, Last) FAYE DENISE GREEN	2. Date of Month Febru	Death Day Year 3. Time of Death						
	Examir Funeral Director	ner	Civista Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1.	aPlata fear f Under 24 Hrs. 8. Date of April 24 Month, (Month)	Charles Birth Day, Year) 2, 1969 Charles 9. Birthplace (State or Foreign Country) Washington DC						
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death v bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 238 eny injury or other treumatic event, it a Micra Examiner mental once. To Be Completed by Funeral		To Be Completed by Funeral Director	Maryland Charles Waldorf	0601 of Hispanic Origin? (Specify Yes or Cuban, Mexican, Puerto Rican, etc.) No Specify: ccupation for during most of working etired) 18. Mother's Name (First, Mid Myrtle Cor Myrtle Cor Creet and Number or Rural Route Number of Rural Route Number of Pulace) em. 2-14-2004	Specify:Black 16b. Kind of Business/Industry Verizon Idde, Maiden Sumame) Tbin Imber, City or Town, State, Zip Code) MD 20735 20c. Location - City or Town, State Clinton, Maryland I's Funeral Home of MD, I						
of Vital Records, P.O. Box 68/60,	Physicien: The law requires that the death certificate be executed x been signed by the attending physicien and aidirector, page 2 should be detached for use as the burial-transit are.	ertification: To Be Completed by Physician/Medical Examiner	23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due	ancy ancy ancy ancy ancy be given in Part I. 23e. D 24a. W an 24a. W an 26. Place of Death (Check on Other: 4 Nursing Home 5 R Injury at Work? 1 Yes 2 No 28f. Location 28f. Location	23d. Date of delivery Month Day Year id tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 Yes 2 No 1 Yes 2 No						
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1	(30)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 F	ME Penn Street, Balt	February 10, 2004 Fimore, Maryland 21201						

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 1 3 2004

			1 - For State Registrar/AMFND#24aperMD	State of Ma	arylano	d / Depa	artmei	nt of H	ealth a	and M	ental Hy	giene Reg. No	21	004	05	991
			HegistrarAVIFIND#24a(DEIIVID Decedent's Name (First, Middle, Las		MDD				Journ		2. Date of De	ath			3. Time of	Death
	Physici		Genevieve	Marie	Gr	ciffit	hs				Month Februar	Da CV 5	, 20	Year 04	12:00	\mathbf{p}^{M}
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	-		-	, Town, or	Location of					of Deeth	12.00	
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σ.	Funeral		Social Security Number 6. S	7. Ag		ast birthday)	If Unde Months	or 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)		9. Birthp	lace (State of	or Foreign
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	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside Ci	ity Limits
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ê E	Pages nent of I unt: If its ury or o	•	1 ☐ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify		Gat	e of		etery	ı F	eh 9	,2004	Sil-	zer	Sarir	MD.	
Baltimore,	그 든 뿐 중		21. Signature of Funeral Service Licen			22	Name :	and Address	s of Facilit	tv				3	15. 1110	
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J Of			27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o	ıf	28c. Injury Work	at c?		28d. Describe	how inju	ry occurr	red		
Ö	Attending r death. sctor: After by the fune	atic	2 Accident investigation	1			М	10	Yes 2□	No						
Division	i or Att after de Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. (Specify	me, farm, st /)	reet, facto	ry, office			28f. Location (. City or To			er or Rura	il Route Num	ber,
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	W		30. Name and address of person who	completed cause of	leath (Item	23a) (Tuno	Print	D 098	834			Febr	cuar	y 6,	2004	
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	St	ate	Barry Rosenbaum, 31. Date filed (Month Day Year) FEB 1 1 200	32. Registr	ar's Signa	TARILE		all		ngro	n, Mary	Land	1	093		
	Regist		FEB 1 1 200	14 Jane	0	P	ap	ces								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05995 State of Maryland / Department of Health and Mental Hygiene 2 1 1 4 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANUARY 31. RAYMOND WILLIAM GORDON, SR. 2004 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES MALCOLM GROW HOSPITAL CENTER AAFB If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Min. 1**X**XM 2□ F Hours Yrs. VIRGINIA 76 09. **Director** 231 30 5334 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ehow. 10a, State 10b. County r than "netural", or Items 23e or 28e-f ehov The Maxical Expanier aust be notified at 1XXYes 2 □ No Director MARYLAND PRINCE GEORGES FORESTVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20747 UNITED STATES 6616 INSEY STREET 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 □Yes ※No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2XXXVo Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER PRIVATE 10TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be d 2 should be fi h and Mental P 7 ie marked ot JAMES LANDER GORDON MARY DALLAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 le
any injury or other trau DESSIE R. GORDON / WIFE FORESTVILLE, MD 20747 6616 INSEY ST. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) RESSURECTION CEMETERY 02/07/2004 CLINTON, MD 21. Sign turn of Filheral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. aves 4308 SUITLAND RD. SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CANCER OF COLON 6 MONTHS /Medical Due to (or as a consequence of) Examiner HYPERTENSION 10 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Y∑Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes X2√ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient XX EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2\(\times No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? nerel Director: After th 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 5 Pending 1XXNatural 2 Accident 1 ☐ Yes 2 ☐ No death. investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after To the Hospital o within 24 hours aff To the Funerel Di completely filled in XXCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20727 FEBRUARY 05, 2004

State Registrar

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760

Division of Vital

REMUKA GUPTA, M.D 31. Date filed (Month, Day, Year) FEB 1.0 2004 FEB

22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

HANIOVER

PKWY

GREENBELT, MID

			For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of <i>rtificate of</i>	Health and I Death	Mental Hy	giene 2	004	0599
4	Dhusisi		1. Decedent's Name (First, Middle, Last,)				2. Oate of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		JASMINE GILBERT 1 28 2004						4:17 P M		
ł	4a. Fecility Name (If not institution, give street and number) 2218 COLUMBIA PLACE						4b. City, Town, or Location of Death LANDOVER			y of Death	OCE! C
_	Funeral		5. Social Security Number 6. Sec.		If Under 1 Yea	If Under 24 Hrs					
L	Director		227-69-4558	^{™ 2} ♥ 9	Yrs.	Months Days	Hours Min.	2 4	1994		INGTON, DC
	pud *		Usuel Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10	d. Inside City Limits
	Maryla f sho	ō							1 XYes 2 No		
	r 28a-	rect	10e. Street and Number 10f. Zip Code							g. Citizen of What Country?	
altimore, Maryland 21215-0036	th with	alD	2218 COLUMBIA PLACE			20785			U.S.A.		
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturai", or items 23a or 28a-f show event, I'm Medical Exacitrat must be rediffed at	by Funeral Director	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer o Specify:	Specify Yes or No to Rican, etc.)		ce - America ick, White, e fy: BLA	etc.
	C 2	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NONE 16b. Kind of Business/It					Business/Ind	ustry		
	Hygie Hygie other ant, II	To Be Co	17. Father's Name (First, Middle, Last)		I NC	'NL	18. Mother's Na	me (First, Middle,		me)	
			REGINALD POINDE	EXTER			NOR	MA GIL	BERT		
	and and is m		19a. Informant's Name/Relationship (7)				et end Number or Ri				
	ealth m 27		NORMA G. ELDRIDGE	•		Sition (Name of	A PLACE L.	ANDOVER,	MARY LA 20c. Location		
	permit. Peges 1 and Department of Health Important: if item 27 any injury or other to		20a. Method of Disposition 1 ■Burial 2 □ Cremation 3 □ F	Removal from State	cemetery, crer	matory or other pi tion Cem		2004			
Ħ	artme ortani injury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Fuheral Seprice Licens			. Name and Add			Clinton NKINS F		
ñ	Dep Imp		6 6 3	/ L ~		7474 LAN	DOVER ROA	D LANDO	VER, MA	RYLAND	20785
P.O. Box 68760,	Physician and /Medical Examiner but sit the partial transit	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line WILMS TUMOR Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
	res thet the death certificate signed by the attending phys be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	o. 23c. If yes, outcome of pregn 1	al death 3	Ectopic pregnan	су		M		Dey Year
	signed be de	by	Part II. Other algithmatic conditions continuously to could be not received and another activities.								
örd	w requir been si should	Completed	1 Yes 2 No 3 P							sy findings available	
Re	The law le has age 2 a	dwo						autor	osy ormed?	prior to con	npletion of cause of
ā	ien:] rtifical	e e	25. Was case referred to medical				26. Place of De	ath (Check only o		10103	243 110
Division of Vital Records,	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be deliached for use at	To B						g Home 5X Residence 6 □ Other (Specify)			
		:lon:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		28d. Describe I	Describe how injury occurred		
		Medical Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital within 24 hours at To the Funeral completely filled		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the within To the comple	Σ	29b. Signature and title of certifier			29c. License number			29d. Date signed (Month, Day, Year)		
^	(1)	The state of the s	1 Heta Y. De	ealf "11	\ -	DU) DOLY	1	0	5-6	4
R			30. Name and address of person who c NITA SEIBEL M.				. WASHING	TON. DC	20010		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature			20119 100	20010		
	Regist		FEB 1 0 2004	Bleech. K	board						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** HELEN FRANCES GALAMBOS 11 00 AM FEBRUARY 07 200 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Brooke Grove Remadultation and with SANDY SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Min Hours 1 □ M 2 🛱 F 87 194-16-3051 Director 8/17/1916 Penna Usuat Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or Itams 23a or 28a-f show other traumetic event, the Medical Examiner must be notified at Sandy Spring MD Montgomery 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20860 18131 Slade School Road USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna Koros Aaron Gainer ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13313 Elliott Drive Clarksville, Md. 21029 19a. Informant's Name/Relationship (Type, Print) R.I.Gainer/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Metropolitan Crem2/09/04 Alexandria, Va 4 Donation 5 Other (Specify) 21. Signature Funer I Service Live PAILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 May 23a. Part1. Enter the disease, or comptications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition VASCULAR **Physician** DEMENTIA YEARS resutting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, physician as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Day Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Home 5 - Residence 6 Other (Specify) 1 ☐ Yes 2 No in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pendina 1 Tyes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide pellij Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number D42046 TRACE BROXEHUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING MARYLAND 20860 - STAFF PHYSICIAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 1 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For 2-12-04 State Registrar Amend #20b.Per F.H.RCC cr 05998 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** 2004 /Medical 4b. City County of Deeth give street and number) Town, or Location of Death 4a. Fecility Name (If not institution, Examiner HOSP tal lary Year If Under 24 Hrs. 9. Birthplace Country) 8. Date of Birth Month, Dey, Social Security Number 6. Sex 7. Age 1 Year **Funeral** Days Min Hours 1 □ M 2 KF Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exercities must be notified at 1 Yes 2 No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ö Si rive or Items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed by 3 Widowed 4 □ Divorced Year or Dates "naturs!" 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than condary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Depertment of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Itas. 2002. 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Ihomas sennie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Rrint) -Forestville, MD 20747 Anderson/Grand 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Amherst, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Home, INC. reene Funeral Ely Franklia elson E well 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final esh ve **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner -(cite Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Kunknown al emia 2 No page 2 should Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 2 No 1 Yes them in or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 2 🗆 No investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100 038032 10/ 2-9-04 Kista taway Rue 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) (37) STR MC/HMA/) F (401/A. 1221)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 1 2 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician HERBERT** 2004 9 10 P Maybe11 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 0akland Garrett Cuppett-Weeks Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 28 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 ☐ M 2 🖾 F Yrs 1916 South Carolina 87 Director 578--03--3973 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r than "neturel", or Items 23a or 28a-f show the Medical Examiner must be rediffed at 1 ☐ Yes 2 ☑ No Director Swanton MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21561 IISA 2501 North Glade Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify. ð 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Magazine Publication Service Representative permit. Pages 1 and 2 should be filled w Department of Health and Montal Hygien Importent: If item 27 is marked other transfer any niury or other traumatic svent, the ODGs. 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Minnie Maxwe11 Cremton Turner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20413 Sawgrass Drive, Montgomery Village, Md 20886 Carl Herbert/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Garrett Co. Mem. Gdns 2/10/04 Oakland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Pneumonia week /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Diabetes Mellitus years Due to (or as a consequence of): Examine the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical as **JF FEMALE** 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year signed by the atte 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown rheumatoid arthritis been 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hypothyroidism I or Attending Physicien: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ctor: After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral I To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D15333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 311 N. 4th St., Oakland, Md. 21550 Thomas G. Johnson M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 2004 Registrar

ORIGINAL

			State of N 1- State Registrar Amend Item#7perFHG8282/2	laryland / Depa 26/04 EW Cea	artment of Heartificate of De	alth and Mer	ntal Hygie	ene 2004	06000	
	Physici	an	1. Decedent's Name (First, Middle, Last) JESSE JOSEPH HEAVNER				Date of Death Month	Day Year	3. Time of Death	
	/Media	cal					7	4 O4	0,10	
1	Examir	ier	4a. Facility Name (If not institution, give street and number Sacred Heart Hospital	4b. City, Town, or Location of Death			4c. County of Death Allegany			
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)		f Under 24 Hrs. 8.	Date of Birth		place (Stete or Foreign	
н	Director		236-42-0104 ¹ X ^{M 2□F} 7	74 -75 Yrs.	Months Days I	Hours Min. N	Date of Birth (Month, Dey, Yi OV. 7, 1	929 WEST	VIRGINIA	
	pur 🛊		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d, Inside City Limits	
	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examina, must be notified an angle.	0	WV MINERAL	FORT AS					1 ☐ Yes 2X No	
		rect	10e. Street and Number	10111	10f. Zip Code		10g	. Citizen of What Co	untry?	
		aiD	ROUTE 2, BOX 297		26719			U.S.A.		
36		y Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceder Armed Forces 1 Yes 2 Married 1 Yes 2 Married 1 Yes 2 Married 1 Yes 2 Married	No	Was Decedent of Hispa If Yes, specify Cuban, N 1 ☐ Yes 2 No S	anic Origin? (Specify Mexican, Puerto Rica Specify:	/ Yes or No- an, etc.)	14. Race - Amer Black, White Specify: W.		
5-0036		To Be Completed by	15. Decedent's Education	16a Dece	dent's Usual Occupatio	on , , , ,	16	b. Kind of Business/l	ndustry	
215	within 72 ene. then "nu		(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4ol	541	kirid of work done duri DO NOT use retired)					
21	should be filed with ind Mental Hygiene s marked other the umatic event, the		7	P	MAIL CARR			U.S. M	AIL	
Maryland			17. Father's Name (First, Middle, Last) CHARLES EDWARD HEAVNE	2		LENA VII				
Man	12 sho h and 7 Is ma trauma		19a. Informant's Name/Relationship (Type, Print) WILMA HALL / NIECE		ng Address (Street and			-		
	os 1 and 2 of Heelth Item 27		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Date		c. Location - City or 1		
10	eges ant of t: If It y or o		1X Burial 2 ☐ Cremation 3 ☐ Removal from State 14 ☐ Donation 5 ☐ Other (Specify)	9	matory or other place) MORIAL PAR	2K 02/09/	2004	CUMBERLAN	D. MD	
Baltimore,	permit. Peg Depertment Important: I any injury o		21. Signature of Funeral Service Licensee		Name and Address of PCHURCH FU	Facility INERAL HOM	E, INC.			
			23a. Part1. Enter the disease, or complications that cause	ed the death. Do not ent		260, FORT such as cardiac or re			Approximate Interval Between	
	/Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition. ADVANICED (IOCALLY) SOPHIAC FAL.							
			resulting in death)	s a consequence of):) meet)		ACCIN	INMA	2003	
2.5			Sequentially list conditions, if any, leading to immediate b. Due to (or a			O F	TRUCT	70 777	2005	
		Examiner	Cause (Disease or injury							
	sate be executed physicien and the burial-transit	xar	that initiated events c.	s a consequence of):				(-)		
8760,	e be e	icai E	d				1 //			
9	tificating phy	ed	<u> </u>			X	Hal I	FEI	3 9 2009	
O. Box	To the Mospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit	Physician/M		2 Fetal death 3	Ectopic pregnancy Other (specify)	C*		23d. Date of deliv Month	very Day Year	
<u>α</u>		e Completed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probebly 4 Unknown							
Records,							24a. Was an autopsy performed	prior to or death?	opsy findings available ompletion of cause of	
Vital			25. Was case referred to medical		26	3. Place of Death (Cl	1 ☐ Yes 2 🔀	(NO ID 165	2 110	
\S		To B	examiner? 1 Yes 2 No released Hospital: 1 Napat	ient 2 ER/Outpatien	t 3 DOA Other:	4 Nursing Home	5 Residence	e 6 Other (Spec	fy)	
ion of		ation:	27. Manner of Death 1	ay Year) 28b. Time of Injury	Work?	28d.	Describe how i	injury occurred		
Division		Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Ir building,	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. De						stated. o the cause(s)		
~	To the comp	ž	29b. Signature and title of certifier	7/	29c. License nu			Date signed (Month,		
9	6		PULL		D 33			spray;		
	MLS		Dr. Gamor Zaman 6	d aderess of person who completed cause of death (Item 23a) (Type, Print)						
10	Sta Registi		7 0 0004	trar's Signature	Source					